wellstone
acupuncture

PATIENT INFORMATION

Name: _____
(First MI Last)
DOB: __/__/__ Age: _____ Gender: M / F Today's date: _____/_____/_____
Address: _____ City: _____
State: _____ ZIP: _____ Marital Status: S / M / D / W / Partnered
Email (used to send you office information only): _____
Phone: _____(home) _____(work) _____(cell) _____
Preferred contact # (circle one): home/work/cell/text

Emergency Contact Information:
Name: _____ Relationship: _____
Address: _____ Phone: _____
Whom may we thank for referring you? _____

What condition(s) are you seeking help with today? (list in order of importance)

	Condition	Effect on your life
1.		
2.		
3.		

Have you received acupuncture or taken Chinese herbs before? Y/N
If yes, approximate date of last treatment: _____
What was the purpose of the visit/herbal formula? _____

Medications/Supplements/Vitamins (list prescriptions, OTC medicines, & natural substances you are currently taking)

	Drug/Substance	Dosage
1.		
2.		
3.		

Allergies (list allergies or sensitivities to any drug or natural substance, including when the allergy started)

	Drug/Substance	Reaction
1.		
2.		
3.		

Hospitalizations/Operations

Date and Reason for hospitalization/procedure Outcome

1. _____
2. _____
3. _____

MEDICAL PROVIDER INFORMATION

Please list your current medical doctors and/or healthcare providers: _____

_____

Physician/Other Provider Address Phone # (if known) _____

_____

FAMILY HISTORY (check only those that have affected up to 2nd degree relatives):

Autoimmune disease	Who _____	Type _____
Cancer	Who _____	Type _____
Cardiovascular disease	Who _____	Type _____
Clotting disorders	Who _____	Type _____
Diabetes	Who _____	Type _____
Mental Illness	Who _____	Type _____
Reproductive difficulty	Who _____	Type _____
Stroke	Who _____	Type _____
Thyroid disease	Who _____	Type _____

SOCIAL HISTORY

1. Do you typically eat at least three meals per day? Y/N If no, how many? _____
2. Exercise routine: _____
3. How many hours per night do you sleep? _____ Do you wake rested? Y/N
4. Level of education completed: (circle one) High School/Bachelors/Masters/Doctorate/Other
5. Occupation: _____ Employer: _____
Hours/Week: _____ Do you enjoy work? Y/N
6. Do you currently (or have you in the past) consume any of the following?

Substance	Y/N	Amount	How Often?	How Long?
Alcohol:				
Caffeine:				
Cigarettes:				
Drugs:				

MEDICAL HISTORY

Last Annual exam: Date_____ Result_____
Last Blood Pressure: Date _____ Result_____
Last Diabetes Screen: Date_____ Result_____
Last Cholesterol Screen: Date_____ Result_____
Last Prostate Exam: Date _____ Result _____
Childhood Illnesses (check all that apply):
☐ chicken pox ☐ diphtheria ☐ measles ☐ mumps ☐ recurrent ear infections

Which of the following are you experiencing or experienced in the past? (mark "C" for current; "P" for past)**:**

Cardiovascular
□ chest pain
□ cold hands/feet
□ heart disease
□ heart murmur
□ high blood pressure
□ high cholesterol
□ palpitations
□ stroke
□ varicose veins

Dermatologic
□ acne
□ age spots
□ allergic dermatitis
□ carcinoma
□ eczema
□ hives
□ itching
□ psoriasis
□ rash
□ rosacea
□ sensitive skin
□ shingles

Ear/Eye/Nose/Throat
□ ear ringing
□ frequent ear infection
□ loss of hearing
□ glasses/contacts
□ glaucoma
□ impaired vision
□ dry eyes/tearing
□ nosebleed
□ sinus problems
□ sneezing/runny nose
□ dry mouth
□ sore throat
□ grinding teeth/TMJ

Emotional
□ abuse
□ addiction
□ anxiety
□ depression
□ frustration
□ mental tension
□ mood disorder
□ overwhelm
□ stress

Endocrine
□ adrenal fatigue
□ diabetes
□ hyperthyroid
□ hypothyroid
□ hypoglycemia
□ hormonal imbalance

Energy/Immunity
□ allergies/hayfever
□ anemia/easy bruising
□ auto-immune disorder
□ cancer
□ Chronic Fatigue
□ easily tired
□ exotic disease
□ fibromyalgia
□ high fever
□ infectious disease
□ slow wound healing

Gastrointestinal
□ abdominal pain
□ belching
□ change in appetite
□ constipation
□ diarrhea
□ gallstones
□ gas/bloating
□ heartburn/acid reflux
□ hemorrhoids
□ liver disease
□ ulcer

Genito-Urinary
□ bloody urine
□ frequent urination
□ incontinence
□ kidney infection
□ kidney stones
□ UTI

Musculo-Skeletal
□ back pain
□ broken bone
□ injury/trauma
□ joint pain
□ muscle cramps
□ neck/shoulder tension
□ weakness

Neurologic
□ dizziness
□ headache/migraine
□ head injury
□ numbness/tingling
□ paralysis
□ seizures

Respiratory
□ asthma
□ bronchitis
□ emphysema/COPD
□ frequent cold/flu
□ persistent cough
□ pneumonia
□ shortness of breath