

Personal Information

Date:

Patient Name:	Last	First	Middle
Address:			Zip Code
Telephone:	Home	Cell	Work
Email:	Fax:		
Date of Birth:	Age	Gender	
Emergency Contact:	Tel:		Relationship
Referred By:			
Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____		

Employment Information

Employment Status:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student		
Occupation:	Employer Name:		

Primary Healthcare Provider

Primary Physician:	Tel:
Physician Address:	Date of Last Visit:

Insurance/Super-bill Information

Insurance Company:	Policy Holder's Name:
Policy Name (if applicable):	Employer Name (if applicable):
Policy Number:	
Insurance Company Tel:	Insurance Company Fax:

Illness and Treatment Information

Have you had acupuncture before? No [ ] Yes [ ] If yes, when and for what reason?

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Are you presently being treated for a medical condition? No [ ] Yes [ ] please describe

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What are your goals for your health? What health issues do you want to address?

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What other medical or treatment therapies are you currently receiving?

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Other health concerns & Information I should know about you:

Family History Information

	Self	Mother	Father	Sister	Brother	Child
Allergies						
Blood Disorders/Anemia						
Diabetes						
Cancer/Tumors						
Heart Disease						
High Blood Pressure						
Kidney or Bladder Disorder						
Stomach or Intestinal Disorder						
Endocrine or Thyroid Disorder						
Tuberculosis						
Seizures						
Stroke						
Depression/Mental Illness						
HIV, Hepatitis, HPV						
Drug/Alcohol Abuse						

Major Hospitalizations

Year	Operation or Illness	Hospital Name	City, State
Year	Operation or Illness	Hospital Name	City, State
Year	Operation or Illness	Hospital Name	City, State

Medicine: list current medications

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Acetaminophen (Tylenol)
<input type="checkbox"/> Oral Contraceptives	<input type="checkbox"/> Laxatives	<input type="checkbox"/> Fiber Supplements
<input type="checkbox"/> Sleeping Pills	<input type="checkbox"/> Tranquilizers	<input type="checkbox"/> Cold Tablets
<input type="checkbox"/> Diet Pills	<input type="checkbox"/> Antacid	<input type="checkbox"/> Hay Fever Tablets
<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Blood Thinning	<input type="checkbox"/> Insulin, Diabetic Meds.
<input type="checkbox"/> Vitamins:		
<input type="checkbox"/> Herbs:		
<input type="checkbox"/> Other:		

Drug Allergies: please list

Environment & Diet Allergies: please list

Exercise

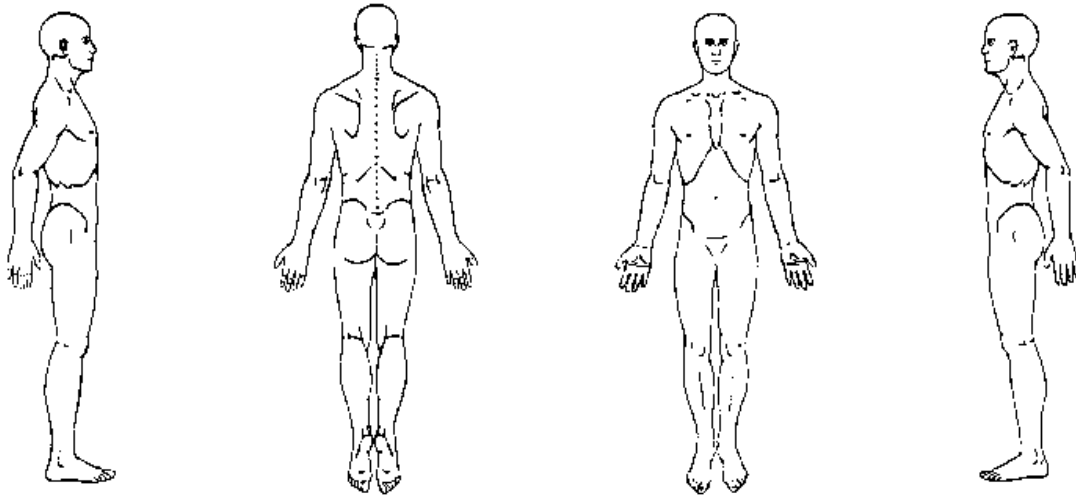
Do you exercise regularly? No  Yes  What type?  
 How often and for how long?

Habits

	No	Yes	Cups per Day / Week	Age started	Age Quit
Coffee					
Tobacco			Cigs per Day / Week		
Alcohol			Drinks per Day / Week		
Marijuana			Use per Day / Week		
Other			Use per Day / Week		

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Musculo-skeletal: please mark an X to indicate areas where you feel pain, swelling, or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area. Be sure to include any chronic pain.



Female Health History: check all that apply \_\_\_\_\_

Are you currently pregnant? No  Yes  How many weeks? \_\_\_\_\_

Birth Control: Oral Contraceptive  Diaphragm  Vaginal Ring  IUD  Other \_\_\_\_\_

Number of: Total Pregnancies  Living  Ectopic  Miscarriages  Induced abortions

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Periods
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Vaginal Infections	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menstrual Periods
<input type="checkbox"/>	<input type="checkbox"/>	Pain/Itching of the Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Leukorrhea/Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Inflammatory Disease	<input type="checkbox"/>	<input type="checkbox"/>	Menopausal Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Fibroids/Cysts	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Male Health History: check all that apply

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Pain/Itching Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Erectile Dysfunction
<input type="checkbox"/>	<input type="checkbox"/>	Genital Lesions/ Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Weak Urinary Stream
<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in Testicles
<input type="checkbox"/>	<input type="checkbox"/>	Other:			

Health History: check all that apply

<b>General</b>			<b>Eyes</b>			<b>Gastro-intestinal</b>		
<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>
[ ]	[ ]	Fatigue	[ ]	[ ]	Blurred Vision	[ ]	[ ]	Nausea/vomit
[ ]	[ ]	Sweats Easily	[ ]	[ ]	Poor Night Vision	[ ]	[ ]	Poor Appetite
[ ]	[ ]	Night Sweats	[ ]	[ ]	Spots	[ ]	[ ]	Excessive Appetite
[ ]	[ ]	Chills	[ ]	[ ]	Cataracts	[ ]	[ ]	Diarrhea
[ ]	[ ]	Fever	[ ]	[ ]	Glasses/Contacts	[ ]	[ ]	Constipation
[ ]	[ ]	Insomnia	[ ]	[ ]	Dryness	[ ]	[ ]	Bloating
[ ]	[ ]	Localized Weakness	[ ]	[ ]	Other_____	[ ]	[ ]	Indigestion/Acid Regurg
[ ]	[ ]	Poor Coordination				[ ]	[ ]	Bad Breath
[ ]	[ ]	Poor Appetite				[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Excessive Appetite				[ ]	[ ]	Rectal Pain
[ ]	[ ]	Change in Appetite				[ ]	[ ]	Gallbladder Disorder
[ ]	[ ]	Strong Thirst				[ ]	[ ]	Other_____
<b>Skin &amp; Hair</b>			<b>Cardiovascular</b>			<b>Neurological</b>		
<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>
[ ]	[ ]	Rashes	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Seizures
[ ]	[ ]	Hives	[ ]	[ ]	Low Blood Pressure	[ ]	[ ]	Tremors
[ ]	[ ]	Eczema	[ ]	[ ]	Blood Clots	[ ]	[ ]	Numbness/Tingling
[ ]	[ ]	Pimples	[ ]	[ ]	Palpitations	[ ]	[ ]	Paralysis
[ ]	[ ]	Dryness	[ ]	[ ]	Fainting	[ ]	[ ]	Other_____
[ ]	[ ]	Lumps	[ ]	[ ]	Chest Pain			
			[ ]	[ ]	Irregular Heart Beat			
			[ ]	[ ]	Cold Hands/Feet			
			[ ]	[ ]	Other_____			
<b>Head &amp; Neck</b>			<b>Respiratory</b>			<b>Psychological</b>		
<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>
[ ]	[ ]	Dizziness	[ ]	[ ]	Asthma	[ ]	[ ]	Depression
[ ]	[ ]	Fainting	[ ]	[ ]	Bronchitis	[ ]	[ ]	Anxiety/Stress
[ ]	[ ]	Headaches/Migraines	[ ]	[ ]	Frequent Colds	[ ]	[ ]	Irritability/Anger
[ ]	[ ]	Head Feels Heavy	[ ]	[ ]	COPD	[ ]	[ ]	Nervousness
[ ]	[ ]	TMJ/Jaw Tension	[ ]	[ ]	Pneumonia	[ ]	[ ]	Treated for Emotional or
[ ]	[ ]	Other_____	[ ]	[ ]	Cough	[ ]	[ ]	Psychological problems
			[ ]	[ ]	Other_____	[ ]	[ ]	Other_____
<b>Nose, Throat, Mouth</b>			<b>Genito-urinary</b>			<b>Infectious</b>		
<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>	<u>Past</u>	<u>Present</u>	<u>Condition</u>
[ ]	[ ]	Nose Bleeds	[ ]	[ ]	Kidney Stones	[ ]	[ ]	HIV
[ ]	[ ]	Sinus Infections	[ ]	[ ]	Painful Urination	[ ]	[ ]	Hepatitis
[ ]	[ ]	Hay Fever or Allergies	[ ]	[ ]	Frequent Urination	[ ]	[ ]	Syphilis
[ ]	[ ]	Recurring Sore Throats	[ ]	[ ]	Blood in Urine	[ ]	[ ]	Genital Warts/HPV
[ ]	[ ]	Other_____	[ ]	[ ]	Urgency to Urinate	[ ]	[ ]	Herpes
			[ ]	[ ]	Incontinence/Dribbling	[ ]	[ ]	Other_____
			[ ]	[ ]	Other_____			
<b>Ears</b>								
<u>Past</u>	<u>Present</u>	<u>Condition</u>						
[ ]	[ ]	Infection						
[ ]	[ ]	Ringing						
[ ]	[ ]	Decreased Hearing						