Central Coast COMMUNITY ACUPUNCTURE, LLC
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## PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birthdate _____

Occupation _____

Company name _____

Primary physician _____

Physician phone number_____

How did you hear about us?_____

## CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

**Another person we may contact if needed:**

Name _____

Relationship_____

Home phone _____

Work phone_____

**Have you had acupuncture before?** _____

## HEALTH HISTORY

**What are your primary reasons for coming in for treatment?**

1- _____

2 - _____

3 - _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

**Check illnesses that have occurred in blood relatives.**

□Diabetes □High blood pressure □Stroke
□Cancer *type*_____ □Heart disease
□Kidney disease

**Check symptoms you have or have had in the last year:**

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Migraines
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

**Check conditions you have or have had in the past:**

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes
- □ Seizure disorder
- □ Pacemaker

How long has it been since you have had a complete medical exam? _____

## HEALTH HISTORY…CONTINUED

**Check symptoms you have or had in the last year:**

**MUSCLE/JOINT/BONES**

- □ Tremors or Cramps
- □ Swollen joints

Pain, weakness, numbness in:

- □ Arms
- □ Hips
- □ Back
- □ Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other_____

**EYES/EAR/NOSE/THROAT/RESPIRATORY**

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever/allergies
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Phlegm *color*_____
- □ Ringing in ears
- □ Sinus problems

**SKIN**

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Unusual sweating/night sweating

**GENITO/URINARY**

- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Urinary tract infection
- □ Kidney infection/stones
- □ Lowered libido

**CARDIOVASCULAR**

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure (*circle one*)
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack, *when?*_____
- □ Rapid/irregular heart beat
- □ Swelling of ankles

**GASTROINTESTINAL**

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation, *how often*_____
- □ Diarrhea, *how often*_____
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

**BODY TEMPERATURE**

- □ Generally cold/cool
- □ Generally warm/hot
- □ Cold hands & feet
- □ Hot/warm at night

**REPRODUCTIVE (check any that apply)**

- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble
- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Light menstrual flow
- □ Yeast infection

*Women:* Could you be pregnant?_____

## SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ Date _____