

Legal Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
first last

What you would like to be called: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex Assigned at Birth: \_\_\_\_\_

Sexual Orientation: \_\_\_\_\_ Relationship status: S M P D W Other

Address \_\_\_\_\_

Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_  
city state zip

Email \_\_\_\_\_ Would you like to be included in our email newsletter? Y or N

Primary Care Provider \_\_\_\_\_ contact \_\_\_\_\_

Emergency contact \_\_\_\_\_  
name phone relationship

How did you hear of us? \_\_\_\_\_

Have you had acupuncture before? Y or N If so, when was your last treatment? \_\_\_\_\_

Do you have kids? Names & ages: \_\_\_\_\_

Who do you live with? (Circle all that apply) Spouse/Partner Children Friends Alone Other

What is your profession? \_\_\_\_\_

What are you seeking treatment for?	
How long has this been going on?	
What makes it worse?	What makes it better?

Have you sought other treatment for this? If so, please list them and their results

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Please check any illnesses or conditions you currently have or have had in the past:	Have you had any of the following medical tests?
<input type="radio"/> AIDS/HIV <input type="radio"/> Heart Disease <input type="radio"/> Pneumonia <input type="radio"/> Alcoholism <input type="radio"/> Hepatitis <input type="radio"/> Polio <input type="radio"/> Allergies <input type="radio"/> High Blood Pressure <input type="radio"/> Rheumatic Fever <input type="radio"/> Anemia <input type="radio"/> Infectious Disease <input type="radio"/> Seizures <input type="radio"/> Antibiotic Use <input type="radio"/> Jaundice <input type="radio"/> Shingles <input type="radio"/> Asthma <input type="radio"/> Kidney Disease <input type="radio"/> STI's <input type="radio"/> Bleed Easily <input type="radio"/> Mental/Emotional Disorders <input type="radio"/> Stroke <input type="radio"/> Cancer <input type="radio"/> Multiple Sclerosis <input type="radio"/> Thyroid Conditions <input type="radio"/> Chicken Pox <input type="radio"/> Night Sweats <input type="radio"/> Tuberculosis <input type="radio"/> Diabetes <input type="radio"/> Pertussis/ Whooping Cough <input type="radio"/> Ulcers <input type="radio"/> Epilepsy <input type="radio"/> Vascular disease <input type="radio"/> Glaucoma <input type="radio"/> Pacemaker	<input type="radio"/> Cholesterol      Date:      Results: <hr/> <input type="radio"/> Hepatitis      Date:      Results: <hr/> <input type="radio"/> HIV test:      Date:      Results: <hr/> <input type="radio"/> Mammogram:      Date:      Results: <hr/> <input type="radio"/> High Blood Pressure      Date:      Results: <hr/> <input type="radio"/> Pap Smear      Date:      Results: <hr/> <input type="radio"/> Physical      Date:      Results: <hr/> <input type="radio"/> Thermography      Date:      Results: <hr/> <input type="radio"/> Stool      Date:      Results: <hr/>

Have you had your appendix removed?      Y or N      Date:

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Have you had your gallbladder removed?      Y or N      Date:

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Have you had ovaries or uterus removed?      Y or N      Date:

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Have you been exposed to antibiotics or steroids?      Y or N      Date:  
 If so, for what condition(s)?

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Were you born prematurely?      Y or N      How many weeks?

Have you been Immunized for:	Does your Family have a history of:
<input type="radio"/> Chicken Pox <input type="radio"/> MMR (Measles/ Mumps/ Rubella) <input type="radio"/> Tdap (Tetanus/ Diphtheria/Pertussis) <input type="radio"/> Tetanus Only <input type="radio"/> Hepatitis <input type="radio"/> Varicella Only <input type="radio"/> HPV (Human Papillomavirus) <input type="radio"/> Shingles <input type="radio"/> Flu <input type="radio"/> Meningitis <input type="radio"/> Other _____	<input type="radio"/> Alcoholism <input type="radio"/> High Blood Pressure <input type="radio"/> Allergies <input type="radio"/> Kidney Disease <input type="radio"/> Bleeding Easily <input type="radio"/> Mental/Emotional Disorders <input type="radio"/> Cancer <input type="radio"/> Obesity <input type="radio"/> Diabetes <input type="radio"/> Stroke <input type="radio"/> Epilepsy <input type="radio"/> Other _____ <input type="radio"/> Heart Disease <input type="radio"/> Unsure of Family History

What medications, vitamins, supplements, homeopathics, herbs, etc., are you taking & what are they for?


Have you had any significant life changes over the past 2 years? Y or N If so, please explain below:


Have you had any recent surgeries, injuries, or traumas?


How much time do you take to relax/unwind & what do you do? Example: meditate, read, exercise, yoga, dance, spiritual/religious practice, etc.

How many hours of sleep do you get a night? \_\_\_\_\_ What is your sleep like?

What is your diet like? Please include caffeine, soda, and sugar consumption.

Do you smoke, drink alcohol or use recreational drugs? How much/how many per week?

Circle any of the feelings you have experienced in the last few months?

Please mark the circle that best describes the level of stress for the below listings.

- |             |                  |                  |
|-------------|------------------|------------------|
| Abused      | Persecuted       | Despair          |
| Overwhelmed | Distress         | Sad              |
| Agitated    | Uncertainty      | Restless         |
| Panic       | Paralyzed        | Outraged         |
| Criticized  | Guilty           | Helpless         |
| Muddled     | Fearful          | Grieving         |
| Uneasy      | Aggravated       | Paranoid         |
| Intolerant  | Depressed        | Nervous          |
| Overworked  | Easily irritated | Hopeless         |
| Anxious     | Impatient        | Unable to grieve |
| Intimidated | Annoyed          | Apprehensive     |
| Angry       | Rejected         | Numb             |
| Worried     |                  |                  |

My Family stress is: \_\_\_\_\_  
 none  minimal  moderate  severe

My relationship stress is: \_\_\_\_\_  
 none  minimal  moderate  severe

My work stress is: \_\_\_\_\_  
 none  minimal  moderate  severe

My financial stress is: \_\_\_\_\_  
 none  minimal  moderate  severe

My health stress is: \_\_\_\_\_  
 none  minimal  moderate  severe

Other \_\_\_\_\_  none  minimal  moderate  severe

Other \_\_\_\_\_  none  minimal  moderate  severe

Other \_\_\_\_\_  none  minimal  moderate  severe

<b>For those who identify as (Women, Transgender, Nonbinary, Genderqueer, Gender Fluid, Two Spirit) and menstruate/d</b>	Are you Pregnant? Y or N	If yes, when is your due date?
Date of Last Menses?	Number of Days bleeding?	Age of First Menses?
# of Days between Start of one cycle to start of the next?		
Do you have pain or cramping? Y or N or Occasionally Where/When?		
Flow: Heavy / Normal / Light		Flow Color?
Is there clotting? Y or N If so, what color and size?		
PMS Symptoms: (Mark all that apply)		
<input type="radio"/> Irritable <input type="radio"/> Mood Swings <input type="radio"/> Crying <input type="radio"/> Breast Tenderness <input type="radio"/> Breast Pain <input type="radio"/> Breast Masses <input type="radio"/> Nipple Discharge <input type="radio"/> Fatigue <input type="radio"/> Headaches/Migraines <input type="radio"/> Acne flare-ups <input type="radio"/> Food cravings _____		
# of Pregnancies:	# of Births:	# of Miscarriages:
		# of Abortions:
Vaginal Discharge? Y or N or Sometimes		Do you have a history of yeast infections?
Menopause: Age at onset?	Hot Flashes? Y or N or Occ.	Night Sweats? Y or N or Occ.
Libido Level?		

<b>For those who identify as (Men, Transgender, Nonbinary, Genderqueer, Gender Fluid, Two Spirit)</b>
Prostate Health? <input checked="" type="radio"/> Fine <input type="radio"/> Poor <input type="radio"/> Unknown <input type="radio"/> Prior History of Prostate issues? _____
Sexual Dysfunction: <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes
<input type="radio"/> Prostatitis <input type="radio"/> Hernia <input type="radio"/> Testicular Masses <input type="radio"/> Testicular Sensitivity/Pain <input type="radio"/> Vasectomy
Libido Level:

The above information is true and accurate to the best of my knowledge and I agree to update my practitioner of any changes.

Signature \_\_\_\_\_ Date \_\_\_\_\_