andress acupuncture

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Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender	Date of Birth	Age	Eye Color:	Height:	Weight:
M F	_____ / _____ / _____				

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One*	Phone (Nighttime) # – **Home Work Mobile** *Circle One*
( )	( )

Alternate Phone # – **Home Work Mobile** *Circle One*	Place of Employment	Occupation

Name & Phone Numbers of Partner:	Name & Phone Numbers of Emergency Contact:
Primary ( ) Alternate ( )	Primary ( ) Alternate ( )

E-Mail:

How did you hear about us? *Please circle one and write the name*

Current Patient: __________ Doctor: __________Advertisement: __________ Friend: ________Insurance: ___________
Other:___________

Have you received a Diagnosis for your condition(s)? Y / N If so what:	Have you had Acupuncture before? Y / N
By Whom:	Did you have a positive ☐ Experience ☐ Out come

	Severe	Moderate	Slight	Major Complaint(s), in order of **importance** to you:
1.	☐	☐	☐	____________________
2.	☐	☐	☐	____________________
3.	☐	☐	☐	____________________
4.	☐	☐	☐	____________________
5.	☐	☐	☐	____________________

When/how did this condition occur? Give dates if possible. 1) ____________________

2) ____________________ 3) ____________________

How do these conditions impair your daily activities? 1) ____________________

2) ____________________ 3) ____________________

Treatment(s) you have received for this condition: 1) ______________________

2) ______________________ 3) ______________________

What treatments helped the most? 1) ______________________

2) ______________________ 3) ______________________

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.	**OCCUPATIONAL CONCERNS** Check (√) if your work exposes you to the following:	**DIET & EXERCISE** Check (√) all that apply.
Year	**Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)**		☐ Stress	☐ Regular Exercise
			☐ Environmental ☐ Heavy Typing ☐ Heavy Lifting ☐ Others:	☐ Low-Fat ☐ Low-Carb ☐ Vegetarian
				☐ Other:
				☐ Drink Coffee: Cups/Day
			Occupation: ______________	☐ Drink Soda oz/Day

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 5.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SUPPLEMENTS

Name	Purpose	How Long	Dose	How Often	Last Dose

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If any of the above family members are deceased, please list their age at death and cause. If you require more space, use the space below.

Notes:

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Anorexia / Bulimia											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_______________											
Other:___________________											

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if Not Applicable.

LIVER / GALLBLADDER

________ Irritability / Anger
________ Depression / Stress
________ Headaches / Migraines
________ Visual Problems
________ Red / Dry / Itchy Eyes
________ Gall Stones
________ Dizziness
________ Blurred Vision
________ Feeling of Lump in Throat
________ Clenching of Teeth at Night
________ Muscle Cramping / Twitching
________ Tension
________ Joints/Neck/Shoulder Pain/Tight
________ Poor Circulation
________ Soft / Brittle Nails
________ Emotional Eater
________ Bad Taste
________ Bad Breath
________ Do you Crave: Sour

KIDNEY/ URINARY BLADDER

________ Urinary Problems
________ Bladder Infection
________ Dropped Bladder
________ Incontinence
________ Lack of Bladder Control
________ Weakness/ Pain in Lower Back
________ Decrease Bone Density
________ Feel Cold Easily
________ Cold Hands
________ Cold Feet
________ Low Sex Drive / Libido
________ Excess Sexual Desire
________ Poor Memory
________ Loss of Hair
________ Hearing Problems
________ Cavities
________ Fear
________ Hot Flash/ Night Sweating
________ Do you crave: Salty

Heart / Small Intestine

________ Heart Palpitations
________ Chest Pain
________ Insomnia / Sleep Problems
________ Easily Startled
________ Restlessness / Agitation
________ Vivid Dreams
____
________ Do you crave: Bitter
____

LUNG / LARGE INTESTINE

Bloody Cough
________ Dry Cough
________ Cough with Sputum
________ Nasal Discharge / Circle Color -
________ White Yellow Green
________ Post Nasal Drip / Circle Color:
________ White Yellow Green
________ Sinus Infection/ Congestion
________ Itchy, Red, or Painful Throat
________ Dry Mouth/ Throat/ Nose
________ Skin Rashes / Hives
________ Snoring
________ Grief / Sadness
________ Shortness of Breath
________ Allergies / Asthma
________ Low Resistance to Colds or Flu
________ Sneezing
________ Mild Fever Comes & goes
________ Smokes Cigarettes
________ Emphysema
________ Bronchitis
________ Black / Blood in Stools
________ Constipation
________ IBS
________ Colitis/ Spastic Colon
________ Diarrhea

Do you Crave : Pungent

SPLEEN / STOMACH

________ Heaviness Anywhere in the Body
________ Fatigue on a Scale of 1(**low**) –10 (**high**)
________ Hard to get up in the Morning
________ Muscles Feel Tired Often
________ Edema (swelling) □ hands □ feet
________ Easily Bruising & Bleeding
________ Bad Breath
________ Nausea/ Vomiting
________ Difficulty Digesting Fatty Foods
________ Nausea/ Vomiting
________ Gas / Belching
________ Hemorrhoids
________ Constipation
________ Diarrhea
________ Abdominal Pain
________ Indigestion / Heartburn
________ Over - Thinking
________ Tendency to Gain Weight
________ Brain Foggy
Do you Crave: Sweet