

Patient Name _____ Date _____

Whole Family Wellness Center
New Patient Information

Patient Information:

Patient Name _____ Today's Date _____
Street Address _____ Apt # _____
City _____ State _____ Zip Code _____
Home Phone (____) _____ Office Phone _____
Mobile Phone (____) _____ Email _____
Birth Date _____ Age _____ Gender _____

Single ___ married ___ divorced ___ widowed ___ domestic partnership ___ other _____

Referred by: _____

Emergency Contact _____ Relationship _____
Home Phone (____) _____ Office/cell phone _____
Physician's Name _____ Phone _____
Date of last visit _____

Employment (please check all that apply):

full-time ___ part-time ___ self-employed ___ student ___ unemployed ___ retired _____

Occupation _____ Number of hours of work/study per week _____

Employer's Name _____ Phone (____) _____

Billing and Insurance

Primary Insurance _____ Phone (____) _____
Primary Insurance Address _____
Policy Holder's Name _____ Relationship _____
Policy # / ID# _____ Group # _____

Missed Appointment Policy

If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in being charged \$55.

_____ I understand cancellation policy.

Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Patient Name _____ Date _____

Health History

Have you had acupuncture treatment before? If so, for what reason? _____

Digestion

past current

- nausea / vomiting
- belching
- heartburn
- bad breath
- bleeding gums
- ulcers
- excessive appetite
- change in appetite
- nose bleeds

past current

- gas
- abdominal bloating
- abdominal pain
- decreased appetite
- indigestion
- low energy / fatigue
- crave sweets
- decreased sense of taste/smell
- difficulty swallowing

past current

- diarrhea
- constipation
- blood in stools/black
- pus in stools
- hemorrhoids
- anal fissures
- rectal pain
- gallstones
- crave sour foods

Respiratory/Skin/Head

past current

- frequent colds
- sinus infection
- production of phlegm
- hay fever or allergies
- dry eyes
- red eyes
- itchy eyes
- aversion to wind
- chills

past current

- pneumonia
- bronchitis
- itching
- dry skin
- acne
- eczema or psoriasis
- ear infections
- night sweats
- enlarged lymph

past current

- laryngitis/hoarse voice
- crave pungent foods
- COPD
- asthma
- recurring sore throat
- cough
- cough with blood
- fevers
- sweat easily

Urinary / Reproductive

past current

- frequent urination
- urgency to urinate
- pain on urination
- urine incontinence
- weak urine stream
- blood in urine
- kidney stones
- low back pain
- sore / weak knees
- crave salty foods
- frequent or strong thirst
- decreased libido
- genital lesions
- genital discharge

(Females only)

past current

- frequent urinary tract infections
- frequent vaginal infections
- pelvic inflammatory disease
- abnormal PAP smear
- irregular periods
- premenstrual syndrome
- painful menstrual periods
- abnormal bleeding
- menopause symptoms
- breast lumps

(Males only)

past current

- impotence
- premature ejaculation
- testicular lumps
- prostatitis
- genital itching/pain

Females only:

Total Pregnancies _____
 living _____ Ectopic _____ Miscarriages _____ Induced Abortion _____

Age of first menses: _____

Age of menopause: _____

Type of birth control you currently use: _____

Patient Name _____ Date _____

Circulation/Heart Meridian

- | | | |
|--|---|--|
| past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> high blood pressure | <input type="checkbox"/> <input type="checkbox"/> chest pain or pressure | <input type="checkbox"/> <input type="checkbox"/> blood clotting disorders |
| <input type="checkbox"/> <input type="checkbox"/> low blood pressure | <input type="checkbox"/> <input type="checkbox"/> jaw, neck, shoulder or arm pain | <input type="checkbox"/> <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> <input type="checkbox"/> palpitations | <input type="checkbox"/> <input type="checkbox"/> poor memory | <input type="checkbox"/> <input type="checkbox"/> crave bitter foods |
| <input type="checkbox"/> <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> <input type="checkbox"/> swollen hands or feet / edema | <input type="checkbox"/> <input type="checkbox"/> cold hands / feet |
| <input type="checkbox"/> <input type="checkbox"/> tend to feel warm | <input type="checkbox"/> <input type="checkbox"/> tend to feel colder than others | |

Nervous System / Emotions

- | | | |
|--|---|---|
| past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> insomnia | <input type="checkbox"/> <input type="checkbox"/> migraines / headaches | <input type="checkbox"/> <input type="checkbox"/> depression |
| <input type="checkbox"/> <input type="checkbox"/> excessive /vivid dreams | <input type="checkbox"/> <input type="checkbox"/> dizziness | <input type="checkbox"/> <input type="checkbox"/> anxiety / stress |
| <input type="checkbox"/> <input type="checkbox"/> grinding teeth | <input type="checkbox"/> <input type="checkbox"/> fainting | <input type="checkbox"/> <input type="checkbox"/> irritability |
| <input type="checkbox"/> <input type="checkbox"/> blurred vision | <input type="checkbox"/> <input type="checkbox"/> seizures | <input type="checkbox"/> <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> <input type="checkbox"/> poor night vision | <input type="checkbox"/> <input type="checkbox"/> localized weakness | <input type="checkbox"/> <input type="checkbox"/> indecisiveness |
| <input type="checkbox"/> <input type="checkbox"/> glasses/contact lenses | <input type="checkbox"/> <input type="checkbox"/> numbness or tingling of limbs | <input type="checkbox"/> <input type="checkbox"/> often feel angry |
| <input type="checkbox"/> <input type="checkbox"/> visual changes | <input type="checkbox"/> <input type="checkbox"/> tremors | <input type="checkbox"/> <input type="checkbox"/> often feel worried |
| <input type="checkbox"/> <input type="checkbox"/> cataracts | <input type="checkbox"/> <input type="checkbox"/> paralysis | <input type="checkbox"/> <input type="checkbox"/> often feel scared |
| <input type="checkbox"/> <input type="checkbox"/> ear ringing – high pitch | <input type="checkbox"/> <input type="checkbox"/> tendonitis | <input type="checkbox"/> <input type="checkbox"/> treated for emotional / |
| <input type="checkbox"/> <input type="checkbox"/> ear ringing – low pitch | <input type="checkbox"/> <input type="checkbox"/> concussion | psychological problems |
| <input type="checkbox"/> <input type="checkbox"/> floaters (spots in the visual field) | <input type="checkbox"/> <input type="checkbox"/> cold sweats | |

Infectious Illness Please mark any **positive** test results you have had:

- | | | |
|---|---|---|
| past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> HIV | <input type="checkbox"/> <input type="checkbox"/> gonorrhea | <input type="checkbox"/> <input type="checkbox"/> SARS |
| <input type="checkbox"/> <input type="checkbox"/> TB | <input type="checkbox"/> <input type="checkbox"/> chlamydia | <input type="checkbox"/> <input type="checkbox"/> west nile |
| <input type="checkbox"/> <input type="checkbox"/> chicken pox | <input type="checkbox"/> <input type="checkbox"/> syphilis | <input type="checkbox"/> <input type="checkbox"/> genital warts |
| <input type="checkbox"/> <input type="checkbox"/> meningitis | <input type="checkbox"/> <input type="checkbox"/> hepatitis | <input type="checkbox"/> <input type="checkbox"/> herpes oral / genital |

Other past or current infectious diseases _____

Recent tests (please indicate results)

Cholesterol _____ Blood pressure _____ Mammography _____
Prostate _____ Blood work _____

Other tests and results _____

Please list any tumors or lumps you currently have or have had in the past:

Pain- please describe any pain you have (L = left, R = right, B = both sides)

- | | | | |
|---|---|---|---|
| past current | past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> head | <input type="checkbox"/> <input type="checkbox"/> forearm L R B | <input type="checkbox"/> <input type="checkbox"/> upper back | <input type="checkbox"/> <input type="checkbox"/> shin l r b |
| <input type="checkbox"/> <input type="checkbox"/> jaw | <input type="checkbox"/> <input type="checkbox"/> wrist L R B | <input type="checkbox"/> <input type="checkbox"/> mid-back | <input type="checkbox"/> <input type="checkbox"/> ankle l r b |
| <input type="checkbox"/> <input type="checkbox"/> neck | <input type="checkbox"/> <input type="checkbox"/> hand L R B | <input type="checkbox"/> <input type="checkbox"/> low back | <input type="checkbox"/> <input type="checkbox"/> foot l r b |
| <input type="checkbox"/> <input type="checkbox"/> throat | <input type="checkbox"/> <input type="checkbox"/> fingers L R B | <input type="checkbox"/> <input type="checkbox"/> hip L R B | <input type="checkbox"/> <input type="checkbox"/> heel l r b |
| <input type="checkbox"/> <input type="checkbox"/> shoulder L R B | <input type="checkbox"/> <input type="checkbox"/> chest | <input type="checkbox"/> <input type="checkbox"/> thigh L R B | <input type="checkbox"/> <input type="checkbox"/> toes l r b |
| <input type="checkbox"/> <input type="checkbox"/> upper arm L R B | <input type="checkbox"/> <input type="checkbox"/> rib / flank | <input type="checkbox"/> <input type="checkbox"/> knee L R B | |
| <input type="checkbox"/> <input type="checkbox"/> elbow L R B | <input type="checkbox"/> <input type="checkbox"/> abdomen | <input type="checkbox"/> <input type="checkbox"/> calf L R B | |

Patient Name _____ Date _____

Family History (Complete for each family member, placing an X in the appropriate box):

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

Major Hospitalizations/Surgeries/Accidents – Please list any hospitalization, surgeries, or injuries you have had:

Year	Operation/Illness/Injury	Name of Hospital	City and State

Medicines, Herbs, Supplements (Please check any that you are currently taking)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> antacids | <input type="checkbox"/> blood thinners | <input type="checkbox"/> sleeping pills |
| <input type="checkbox"/> Ibuprofen pills | <input type="checkbox"/> fiber / laxatives | <input type="checkbox"/> blood pressure | <input type="checkbox"/> tranquilizers |
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> diet pills | <input type="checkbox"/> insulin | <input type="checkbox"/> antidepressants |
| <input type="checkbox"/> allergy medication | | | |

Please list any of the following currently being taken:

Western Drugs	Herbs	Vitamins and Supplements
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Drug Allergies: _____

How many times in the last year have you taken Antibiotics? _____

In the last 5 years? _____

Did you supplement with probiotics (acidophilus)? Yes ____ No ____

Have you traveled to developing countries? If yes, please describe:

Where did you travel?	How long ago?	How much time did you spend there?
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Habits (Please check any habits which apply to you now or in the past)

Coffee	__ yes __ no # per day _____	age started _____	age quit _____
Tobacco	__ yes __ no # per day _____	age started _____	age quit _____
Marijuana	__ yes __ no # per day _____	age started _____	age quit _____
Alcohol	__ yes __ no # per day _____	age started _____	age quit _____
Crack/Cocaine	__ yes __ no # per day _____	age started _____	age quit _____
Heroin	__ yes __ no # per day _____	age started _____	age quit _____

Diet

Please describe any restricted diet you follow(ed) now or in the past:

Please describe your typical daily diet:

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Dinner _____ Evening Snack _____

Food Allergies _____

Food Sensitivities _____

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Please list your health concerns in order of importance:

Please describe any regular program of exercise:

Do you have a religious or spiritual practice? If so, please describe:

What are the top priorities in your life?

What are your expectations and/or hopes for the outcome of this treatment?

Please describe how you might know that you have accomplished these goals?

How do you think reaching your goals for your health will effect your life?

Please provide any additional information about yourself or your condition not covered by the above questions (please use the back of this paper).