Stone BridgeWellness

Acupuncture Patient Information Sheet

NAME:

Email: _____ May we contact you by email? yes/no

Height:_____Weight: _____ Birth Date (month/day/year): _____

Who may we thank for referring you to our clinic? _____

PERSONAL HEALTH HISTORY:

Have you had previous acupuncture care? Yes/No When? _____

List any known allergies: _____

Do you smoke? Yes/No If yes, how many cigarettes/day? _____

Do you consume alcohol? Yes/No If yes, how many drinks/week? _____

Please list any significant previous injuries (fractures, sprains, motor vehicle accidents, etc.): _____

_____

_____

Please list any surgeries you have had and when you had them:_____

_____

_____

Please list any health conditions you presently have or have had in the past (e.g. cancer, anemia, arthritis, epilepsy, stroke, hepatitis, HIV/AIDS, diabetes, etc.): _____

_____

Do you have any local infections or elevated risk of infections? Yes/No

Do you have a pacemaker or any other electrical/metal implants? Yes/No If yes, where? _____

Have you ever had any radiographs/x-rays taken? Yes/No

Where?_____When?_____Results? _____

Are you, or is there a chance that you may be pregnant? Yes/No

Do you have any current or previous blood disorders (high blood pressure, blood clotting problems, infections) Y/N

How many days per week do you exercise? 0 1 2 3 4 5 6 7

How many servings of each food group do you get per day? Meats_____Fruit/Vegetable_____Grain/Pasta___Dairy_____

How many hours do you normally sleep per night? 1 2 3 4 5 6 7 8 9 10 11 12

FAMILY HISTORY:

Please indicate any health conditions regarding your:

Spouse/Partner:_____Mother/Father_____

Siblings: _____ Children: _____

CHIEF COMPLAINT:

Briefly describe your current complaint or reason for your appointment: _____

_____

When did your condition initially begin? _____

Cause of condition (please circle all that apply): motor vehicle accident, work related injury, sudden trauma, reoccurrence, repetitive trauma, unknown, other: _____

What makes the condition feel better? _____

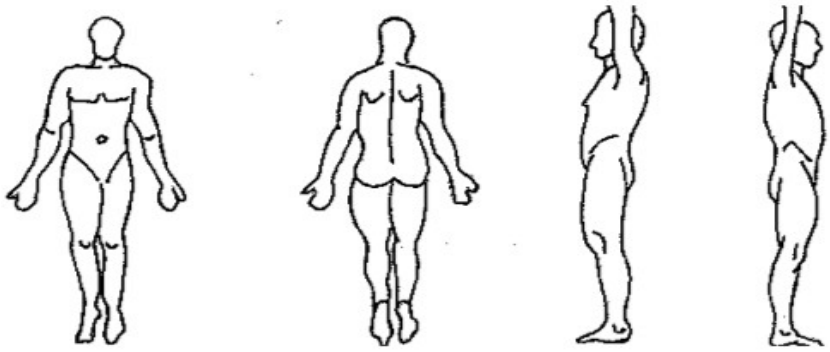
What makes the condition feel worse? _____

Does coughing or sneezing aggravate your pain? Yes/No Do you currently have a fever? Yes/No

Do you have any loss of control with bowel or bladder function? Yes/No

Does the pain ever wake you up at night? Yes/No Do you have any unexplained weight loss? Yes/No

Please use the following drawing to mark the area(s) where you feel the described sensations. **Use the appropriate symbol.**



LEGEND:

A = ACHE

P = PINS & NEEDLES

B = BURNING

S = STABBING

N = NUMBNESS

O = OTHER

Use the scale below to indicate your level of pain today (T), and in general (G):

(0 = no pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (10 = worst pain)

What is your energy level (please circle)? *Low* 1 2 3 4 5 6 7 8 9 10 *High*

What is your stress level (please circle)? *No stress* 1 2 3 4 5 6 7 8 9 10 *High stress*

Mark the treatments that you have received so far for your pain/fatigue or other problems?
Physical Therapy/ Chiropractic/ Naturopathy Relaxation/
Massage Therapy/ Medication/Other Treatments (please specify):

_____

So far, which treatments have benefitted you the most? _____

Please list all of the medications and supplements you are taking and the conditions you are taking them for: _____

_____

What are your treatment goals and expectations from acupuncture? _____

NO SHOW/LATE CANCELLATION POLICY: As a courtesy to other patients and the doctor, we ask that you give us a 24 hour notice if you cannot make it to your scheduled appointment. Our policy is to charge for missed appointments at the rate of the scheduled visit, billed directly to you, and payable prior to your next visit. Please help us to serve you better by keeping scheduled appointments. Thank you.

I have read, understood and agree to the above financial policy.

Name: Signature: Date: