City Pulse Acupuncture

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www.CityPulseAcupuncture.com

Please note that all information is strictly confidential. Please complete as thoroughly and accurately as possible.

First Name:	Middle Initial:	Last Name:	Nickname:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email address:		Email appt reminders? Yes No	
Marital status: Single Married Partnered Divorced Widowed			
Date of birth:	Age:	SSN:	
Gender:	Height:	Weight:	
How did you hear about us? Friend Doctor Advertisement Current Patient Insurance Yelp			

May we correspond with you (invoices, questions, etc.) via email? Yes No
If not, how shall we correspond with you? _____
Have you had an acupuncture treatment before? Yes No For what condition? _____

Employment Status: (✔ all that apply)
Full-time Part-time Self-Employed Retired Unemployed Student

Occupation:	Name of employer:

Emergency Contact:

Relationship:	Phone:

Primary Physician:	Phone:
Physician's Address (or name of clinic/hospital):	
Date of last physical: / /	Date of last blood panel: / /

Insurance Information: If the office will be billing insurance, please complete the following section.

Name of Insurance Provider:	
Insurance Company Address:	Phone:
Policy # / ID #:	Group #:
Policy Holder Name:	Relationship to patient:
Policy Holder Date of Birth:	
Policy Holder Address & Phone Number:	

Reason for Today's Visit:

What is the primary reason for your visit today?

How, when and where did this condition begin?

What types of treatments have you tried, if any?

How does this condition impair your daily activities?

What makes it better or worse?

In order of importance, what are your major complaints?

	Major Complaint	Severity (1-10)	How long?	Better, worse or no change				Pain Level (1-10)
				Heat makes it?	Cold makes it?	Damp makes it?	Exercise or Activity makes it?	
1								
2								
3								

Medical History:

Medications/Vitamins/Supplements – Please list all prescription medications, vitamins and supplements you use. Include those you may only use occasionally. If you don't take any, please note by writing 'none.'

Medication/Vitamin/Supplement	Purpose	How long?	Dosage	How often?	Last dose?

MEDICAL CONDITIONS – Please list Surgeries/Hospitalization/Accidents/Trauma		**ALLERGIES** --	**OCCUPATIONAL CONCERNS --**
Year	Surgery/Hospitalization/ Accidents/Trauma (physical & emotional)	-- Medication -- Seasonal -- Environmental -- Food	Please ✔ all that apply
			Stress
			Heavy Typing
			Heavy Lifting
			Hazardous Exposure
			Other:

Lifestyle:

DIET: Please ✔ check all that apply to your diet ➜	Low fat Vegetarian Standard American Diet Eating Disorder:	Low carb Vegan
How much water do you drink each day? cups	Any food cravings?	
Typical Breakfast		
Typical Lunch		
Typical Dinner		
Typical Snack		

HABITS			**EXERCISE**
	Amount per *week*	If quit, what year	Do you exercise regularly? Yes No If so, what types? What frequency/duration/intensity?
Coffee			
Tea			
Soda			
Alcohol			
Tobacco			
Drugs			

Please indicate current problems areas with a "C". "P" should be used to indicate past problems. If the problem area is chronic, indicate "K".

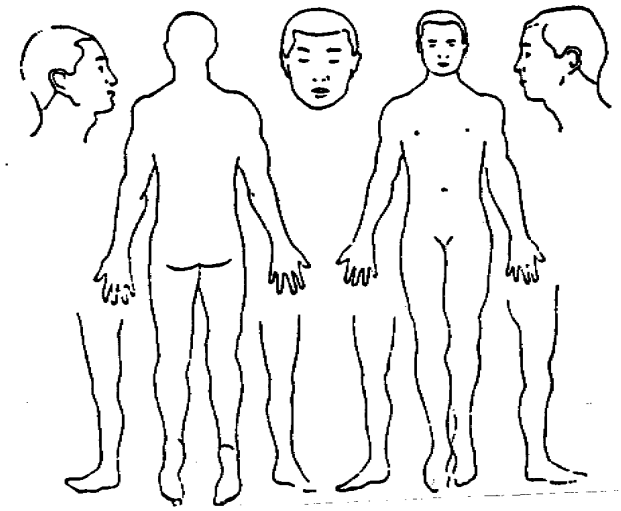
MUSCULOSKELETAL/EXTREMITIES

Pain, weakness, numbness in;

Head	Neck	
Fingers	Hands	Wrists
Elbows	Shoulders	Arms
Toes	Feet	Ankles
Lower Leg	Knees	Thighs
Hips	IT Band	Pelvis
Low back	Mid back	Upper back
---	---	---
Joint swelling	Edema	Carpal tunnel
Broken bones	Tendonitis	Sprains/Strains
Bone deformity	Muscle pain	Rotator cuff
Paralysis	Bursitis	Poor balance
Whole body pain	Sciatica	Limited mobility

Other: _____

Please mark all areas of pain on the diagram:



Personal and Family Health History

Please indicate current health problems for yourself and family members with a "C". "P" should be used to indicate a past problem. Leave blank those that do not apply.

	You	Year	Family		You	Year	Family
Addiction				Hypertension			
AIDS/HIV				Hypoglycemia			
Alcoholism				IBS			
Allergy type(s)				Infertility			
				Kidney Disease			
Anemia				Lyme Disease			
Arthritis				Mental Illness			
Asthma				Multiple Sclerosis			
Candidiasis				Osteoporosis			
Cancer type(s)				Pacemaker			
				Pancreatitis			
Chronic Fatigue				PCOS			
Chronic Pain				Peripheral Neuropathy			
Diabetes				Raynaud's Disease			
Diverticulitis				Rheumatic Fever			
Emphysema				Seizure Disorder			
Gastritis				STI			
Heart Disease				Stroke			
Herpes				Thyroid Disease			
High Cholesterol				Tuberculosis			
Hyperglycemia				Other: _____			

Please indicate current conditions with a "C". "P" should be used to indicate past conditions. If the condition is chronic, indicate "K".

SLEEP

Difficulty falling asleep	Difficulty staying asleep	Excess sleep
Sleepwalk/talk	Dream disturbed sleep	Restless sleep
Not rested upon waking	Wake: _____ x/night	Sleep: _____ hrs/night

ENERGY

Dependent on coffee	Fatigue
Drops after eating	Body feels heavy
Sudden energy drop:	Body feels weak

NEUROLOGICAL, PSYCHOLOGICAL & EMOTIONAL

Vertigo/Dizziness	Seizures	Areas of numbness		
Nervousness	Anxiety	Panic attacks	Irritable	Depressed
Bi-polar	Poor memory	Forgetful	ADD/ADHD	Fearful
Anger	Sadness	Grief	Joy	Indecision
Concussion	Poor concentration	Over-thinking	Tremors	Easily stressed
Seasonal Affective Disorder	Difficulty expressing emotions	Frequent sighing or yawning	Loss of Balance or Coordination	Other:

TEMPERATURE & THIRST

Cold hands & feet	Cold "in the bones"	Chills		
Hot hands	Hot feet	Hot chest		
Hot flashes	Hot at night	Hot in afternoon		
Night sweats	Spontaneous sweats	Unusual sweats?	Where? _____	What time? _____
Thirst for cold drinks	Thirst for hot drinks	Thirst, no desire to drink	No thirst	Excess thirst

HEAD, EYES, EARS, NOSE & THROAT

Migraines	Headaches	Feeling lightheaded/dizzy	
Poor vision	Floaters	Blurry eyes	Eye strain
Color blindness	Cataracts	Red/Itchy eyes	Eye pain
Poor Hearing	Earaches	Tinnitus	Excess ear wax
Poor smell	Sinusitis	Nasal discharge	Nose bleeds
Dry Lips	Dry throat	Difficulty swallowing	Bleeding gums
Mouth sores	Tongue sores	Grinding teeth	TMJ/Jaw pain

Please indicate current conditions with a "C". "P" should be used to indicate past conditions. If the condition is chronic, indicate "K".

SKIN, HAIR & NAILS

Rashes	Eczema	Psoriasis	Dermatitis	Acne
Hives	Itching	Warts	Abscesses/Infections	Ulcerations
Thick skin	Thin skin	Scaly skin	Discolored skin	Dry skin
Thin nails	Dry nails	Brittle nails	Ridged nails	Nail fungus
Hair loss	Dandruff	Dry/Brittle hair	Premature graying	
Face flushing	Lumps	Dark under eyes		Other: _____

RESPIRATORY

Frequent colds	Frequent fevers	Coughing blood	Productive cough	Phlegm
Chest tightness	Shortness of breath	Emphysema	Bronchitis	Color:
Asthma	Difficulty inhaling	Difficulty exhaling	Difficulty breathing reclined	Pain on deep breath

CARDIOVASCULAR

Palpitations	Slow heart rate	Elevated heart rate	Irregular heart beat
High blood pressure	Low blood pressure	Fainting	Hands/feet swelling
Bleed/Bruise easily	Blood clots	Phlebitis	Chest pain/swelling

GASTROINTESTINAL

Bowel Movement (BM)	How often? ___x/__day(s)	Formed? Yes No	Tired after BM	Cramps with BM
Dry stool	Difficult to pass	Diarrhea	Incomplete BM	Foul smell
Undigested food	Mucus	Sink	Float	
Blood in stool	Hemorrhoids	IBS/Crohn's Disease	Excess saliva	Peculiar taste
Indigestion	Bloating	Belching	Gas	Heartburn/Reflux
Abdominal pain	Rectal pain	Poor appetite	Excessive appetite	Lump in the throat

UROGENITAL

Clear urine	Profuse urine	Frequent urination	Dark urine	Scanty urine
Cloudy urine	Burning urination	Urgent urination	Painful urination	Blood in urine
Incontinence	Difficult start/stop	Frequent UTI	Fluid in = Fluid out	Wake up to urinate
Decreased libido	Premature ejaculation	Nocturnal emission	Testicular pain	Genital pain
Excess libido	Herpes	Genital sores	Jock itch	Vasectomy

GYNECOLOGICAL

Are you currently pregnant? Yes No		Are you currently trying to get pregnant? Yes No
Age at first menses:	Date of last menses: / /	Length of cycle: days (0=amenorrhea)
Average number of days of flow?		Flow is: Light Normal Heavy
Color is: Pale Normal Dark Bright red Brown		Are clots present? Yes No
Does your period cause cramping or pain? Yes No		When? Before During After period
Do you get nausea or vomiting with your period? Yes No		When? Before During After period
Do you get any of the following before your period each month? Water retention Breast tenderness or swelling Mental depression Break outs Irritability Food cravings Fatigue Migraines Low Back Pain Other: _____		
Bowel movements loose at the beginning of period? Yes No		Vaginal discharge between periods? Yes No Color:
Date of last pap smear: / /	Ever had an abnormal pap smear? Yes No	When/Why?
Currently using contraception? Yes No	What form and for how long?	
Number of pregnancies:	Number of births:	# of abortions/miscarriages:
Have you experienced menopause? Yes No	When?	
If experiencing menopausal symptoms, please describe:		

Vaginal dryness	Vaginal sores	Vaginal discharge	Painful sex
Endometriosis	Uterine fibroids or polyps	Yeast infections	Pelvic Inflammatory Disease
Fibrocystic Breast Tissue	Ovarian cysts		