2500 S Kanner Hwy Suite 3, Stuart, FL 34994
(772) 403-7640

Patient Information

Name: _____ DOB: _____ SS#: _____ M/F
Address: _____
Phone: _____ Cell: _____ Email: _____
Occupation: _____Employer: _____

Health Insurance Information

Insurance Co: _____
Insured: _____ Patient Relationship: _____
ID #: _____ Group #: _____

Have you had acupuncture before? Yes No

If "yes", for what condition(s)? _____

What are your main concerns?

1. _____ 2. _____ 3. _____

When did each begin?

1. _____ 2. _____ 3. _____

What current treatments are you receiving for your concerns? (Circle all that apply)

Physical therapy/ chiropractic / massage therapy / western medicine/ none/ other _____

Name and location of current treatment provider(s):

_____
_____

Female Patients: Date of last menstrual period? _____ Could you be pregnant? Y ___ N __

Total Pregnancies:_____Live Births_____Ectopic_____Miscarriages_____Induced Abortions ____

Age at last pregnancy: _____ List any problems during pregnancy: _____

_____

What are your health goals?

_____

What are the top 3 priorities in your life?

#1 _____#2 _____ #3 _____

Circle Stress Level (0 =no stress, 10=high stress) 0 1 2 3 4 5 6 7 8 9 10

Recent Health Diagnoses:

_____

_____

List any prescription medications you are currently taking: Continue on back if needed (please check if using back) _____

Medication Name	Reason for Prescription (Condition)	Dosage	Frequency
Medication Name	Reason for Prescription (Condition)	Dosage	Frequency
Medication Name	Reason for Prescription (Condition)	Dosage	Frequency

List any OTC medications you are currently taking

Medication Name	Reason for Taking (Condition)	Dosage	Frequency
Medication Name	Reason for Taking (Condition)	Dosage	Frequency
Medication Name	Reason for Taking (Condition)	Dosage	Frequency

List all herbs & supplements you are currently taking: Continue on back if needed (please check if using back) _____
Please note any that are recommended by a health care provider

Herb/Supplement Name:	Reason for Taking (Condition)	Dosage	Frequency
Herb/Supplement Name:	Reason for Taking (Condition)	Dosage	Frequency
Herb/Supplement Name:	Reason for Taking (Condition)	Dosage	Frequency

Major Hospitalizations/Surgeries – please list any hospitalizations or surgeries within the past 2 years:

Year	Operation or Illness	Name of Hospital	City and State

_____

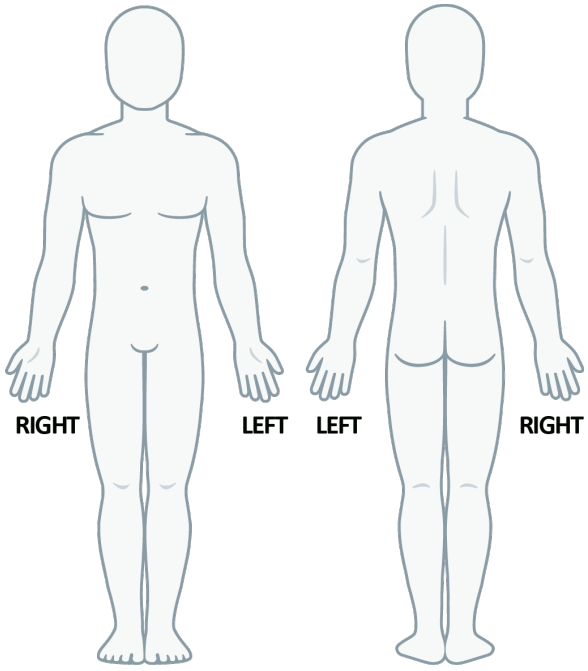
_____

List type and date of past or current infections (MRSA/ C-Diff, etc.)

_____

Why You Are Here

On the diagram below please circle O areas of pain or mark an X for numbness/tingling



Circle quality of pain:

throbbing	shooting
stabbing	sharp
hot burning	aching
heavy	cramping

How long have you had this pain:

3 months or less	3 – 6 months
12 – 24 months	> 24 months

How often does this pain occur?

Continuously	Several times a day
1 or 2 times a day	Several days a week
Less than 4 times a month	

Grade the Intensity/Severity of the above pain: 0= none 10 = worst

0 1 2 3 4 5 6 7 8 9 10

Does the pain radiate, travel, or shoot into any areas of the body? Y ___ N ____
If yes, describe: _____

Circle the cause of the pain: the result of cancer treatment / following an operation / following an injury / no obvious cause /other _____

Are you currently under Chemotherapy or Radiation Treatment: Yes / No
Name of Clinician / Group treating you: _____

Please check all symptoms that you have experienced within the past 6 months:					
	nausea		gas		diarrhea
	vomiting		abdominal bloating		irritable bowel syndrome
	belching		abdominal pain		blood in stool
	heart burn		fatigue/low energy		black stools
	bad breath		decreased ability to smell/taste		pus in stools
	constipation		anal fissures		hemorrhoids
	rectal pain		indigestion		ulcers
	crave sour foods		craving sweets		crave pungent foods

Please check all symptoms that you have experienced within the past 6 months (cont)					
	crave bitter foods		crave salty foods		sweet taste in mouth
	increased appetite		decreased appetite		bleeding gums
	difficulty swallowing		laryngitis / hoarse voice		recurring sore throat
	jaw pain		grinding teeth		COPD
	frequent colds		asthma		sinus infection
	bronchitis		hay fever or allergies		pneumonia
	cough		cough with blood		production of phlegm
	dry skin		hives		eczema/ psoriasis
	rashes		acne		itching
	headache		recurring sore throat		dizziness
	ear infections		ear ringing – low pitch		ear ringing – high pitch
	decreased hearing		immune compromised		enlarged lymph glands
	frequent urination		frequent urinary tract infections		urgency to urinate
	edema		low blood pressure		high blood pressure
	pain on urination		frequent vaginal infections		abnormal PAP smear
	impotence		pelvic inflammatory disease		irregular periods
	premature ejaculation		urine / bowel incontinence		decreased libido
	testicular lumps		genital itching / pain		kidney stones
	weak urine stream		genital lesions / discharges		prostatitis
	blood in urine		chest pain or pressure		abnormal bleeding
	premenstrual syndrome		painful menstrual periods		menopause symptoms
	menstrual cramps		breast lumps		endometriosis
	fibroids/ovarian cysts		fibrocystic breast		infertility
	sore / weak knees		shoulder or arm pain		neck pain
	cataracts		dry eyes		red eyes
	eye inflammation		floaters (spots in visual field)		blurred vision
	poor night vision		visual changes		glasses / contact lenses
	insomnia		excessive / vivid dreams		night sweats
	fainting		localized weakness		seizures
	migraine		depression		anxiety / stress
	poor memory		emotional / psychological problems		irritability
	tremors		numbness or tingling of limbs		poor coordination
	arthritis		tendonitis		paralysis
	indecisiveness		excessive joy		often feel sad
	often feel afraid		often feel pensive / over thinking		often feel angry
	swollen hands or feet		blood clotting disorders		gallstones
	heart palpitations		irregular heartbeat		cold hands / feet
	chills		tend to feel colder than others		fevers
	frequent or strong thirst		tend to feel warmer than others		neck stiffness
	phlebitis		concussion		low back pain
	aversion to wind		cold sweats		sweat easily
	prefer cold food and drink		prefer warm food and drink		
	auto immune disease(s):				

Family History – please complete for each family member by placing an X in the appropriate box:							
	Self	Mother	Father	Sister	Brother	Spouse	Child
Diabetes							
Cancer/Tumor, Type:							
Seizures							
High Blood Pressure							
Drug use / (substance abuse)							
Alcohol abuse							
Heart Disease							
Stroke							
Depression / Mental Illness							
Age at Death							

Diet – please describe any restricted diet you follow now or have in the past:

_____

_____

Allergies – please list any known allergies (food, hay fever, pollen, drugs, medication, etc.):

_____

_____

Sleep:

What time do you typically go to sleep?	**_____am / pm**
How long does it take you to fall asleep?	
What time do you typically wake up?	**_____am / pm**
Do you have difficulty staying asleep?	**Yes / No**
How many times do you get up during the night?	
Do you wake feeling rested?	**Yes / No**

Is your Appetite: Poor / Excessive **Do you eat breakfast? Yes/No**

How often do you drink: Coffee_____ How much? _____
Soft drinks_____ How much? _____ Alcoholic drinks_____ How much? _____

How many 8-ounce glasses of water do you drink per day? _____# of glasses per day

Have your recently gained or lost weight? Yes/No Were you trying to gain or lose weight? Yes/No

Circle all that apply:

Do you crave: Salty foods/Sugar Do you have a strong preference for cold drinks? Yes/No Hot drinks? Yes/No

Please describe what you eat in a typical day:

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks (list time and snack):

_____

_____

How is your dental health? Good / Fair / Poor When was your last visit to the dentist? _____

Do you exercise regularly? Yes / No If yes, how many times per week? _____

Circle all that apply: weight lifting, aerobics, walking, running, cycling, yoga, other _____

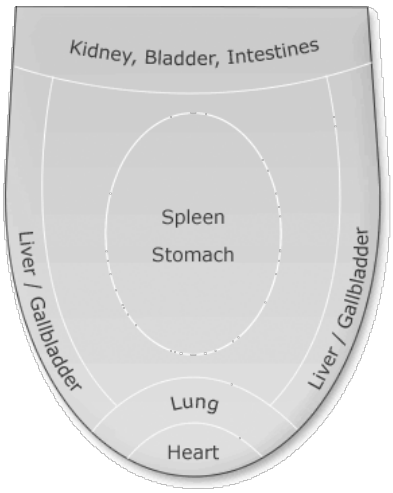
Do you have any spiritual practices? If so, please describe: _____

To be completed by Acupuncturist:

T:
P:

LU/LI:	HT/SI:
SP/ST:	LV/GB:
PC/SJ:	KI/UB:

Assessment:
OM Dx:
OM Tx Principles:



Treatment Plan

Bilateral:
Right:
Left:
Midline:

Tx Methods and Reasoning: Acupuncture pts, Moxa, Cupping, Myofascial Release, Herbal Formula (dosage, administration), Supplements, Dietary & Lifestyle, lab/imaging, referrals

 # _____in # _____out

Follow up: _____ weekly for_____ weeks

Total # of visits _____