Optimal Wellness Acupuncture

New Patient Health Information

Have you ever been treated with acupuncture before?

- ☐ yes
- ☐ no

If yes, for what condition(s):

CHIEF COMPLAINT

What is your primary reason for this visit?

When did your symptoms first begin?

Are the symptoms:

- ☐ Constant
- ☐ Intermittent

What other treatments have you tried for this condition?

What aggravates the condition?

What alleviates the condition?

Health History (Please check all conditions or previous diagnoses that apply)

- ☐ Allergies
- ☐ Cancer: ______________________________

- ☐ Diabetes
- ☐ Hepatitis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Headaches/Migraines
- ☐ Other :

MEDICAL HISTORY

Other diagnoses or health issues affecting your or health:

List any surgeries or hospitalizations:

Please explain if necessary:

Do you have any implants, joint replacement, heart pace maker or other devices?

- ☐ yes
- ☐ no

If yes, please explain:

Please list your current medications:

Please list supplements / herbs that you are taking right now:

PATIENT ALLERGIES AND SENSITIVITIES

Do you have any allergies or sensitivities to drugs, foods, environmental irritants, or other substances?

- ▫ yes
- ▫ no

Please explain:

GENERAL HEALTH

Please check all that apply

- ▫ Insomnia
- ▫ Night sweats
- ▫ Sweating (without exertion or reason)
- ▫ Generalized weakness
- ▫ Significant weight loss
- ▫ Significant weight gain
- ▫ Edema (Swelling in body)
- ▫ Arthritis
- ▫ Generally cold
- ▫ Generally hot
- ▫ Thirst/dry mouth
- ▫ Lack of appetite
- ▫ Excessive hunger
- ▫ Tremors/Trembling
- ▫ Dizziness/Vertigo
- ▫ Tinnitus (ringing in ears)
- ▫ Urinary incontinence

Mental Health

Please check all that apply

- ▫ Depression
- ▫ Anxiety
- ▫ Stress

- ☐ Irritability and frustration
- ☐ Worry (without reason)
- ☐ Poor memory/Forgetfulness
- ☐ Lack of concentration
- ☐ Lack of motivation
- ☐ Hopelessness

Are you pregnant? (Women only)

- ☐ Yes, how many weeks:
- ☐ No
- ☐ Not sure/Maybe

FAMILY HISTORY

List significant illnesses such as easy bleeding, diabetes, cancer, alcoholism, obesity, heart disease, allergy, epilepsy, high blood pressure, mental illness, stroke:

Father:

Mother:

LIFESTYLE AND HABITS

Do you smoke?

- ☐ Yes
- ☐ No

Please explain if necessary:

Alcohol

- ☐ Yes
- ☐ No

Please explain if necessary:

Do you exercise:

- ☐ Rarely
- ☐ 1-2 times per week
- ☐ 2-3 times per week
- ☐ more than 4 times per week

What type of exercise?

How much does stress affect your life on a 0-10 scale? (10 = extreme stress)

What are current major stressors in your life?

What is the major source of joy in your life?

Verification

- ☐ I certify that the information that I have given above is correct and accurate to the best of my knowledge.

Patient Name:

Signature

If signed by patient representative, state relationship to patient: