PATIENT'S PERSONAL HISTORY

This is a confidential record.

Name: _____

Sex:_____ Birth Date: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone _____ Secondary Phone: _____ Email Address: _____

Emergency Contact _____ Phone: _____

Employer: _____ Occupation: _____

How were you referred to our office? _____

Have you ever had acupuncture before?_____

Have you ever been diagnosed with the following? Hepatatis _____ HIV _____ AIDS _____

Are you currently under a physican's care for any medical conditions? If yes, please give your doctor's name and medical condition:

_____

Are you currently taking any prescription medication? If so, please list them here:

_____

_____

Are you currently experienceing any pain? If so, where? _____

Please list any health conditions you would like us to focus on and forms of treatment that you have sought for those conditions:

Condition: _____ Treatment: _____

Condition: _____ Treatment: _____

Condition: _____ Treatment: _____

Condition: _____ Treatment: _____

CONSENT FOR TREATMENT

I, the undersigned, give my permission and consent to treatment. I fully understand that there is no implied or stated guarantee of the success or effectiveness of a specific treatment or series of treatments.

Patient Signature: _____ Date: _____

SYMPTOMS

Please check all of the symptoms you experience.

Love & Light acupuncture

FIRE

__ Heart palpitations
__ Chest pain
__ Dizziness
__ Insomnia
__ Easily startled
__ Restless, agitated, excitable
__ Anxiety
__ Breathlessness
__ Vivid dreams
__ Disturbing dreams
__ Lack of joy in life
__ Laugh/cry easily
__ Bitter taste in mouth upon wakening
__ Easily confused, disoriented
__ Sores of mouth and tongue
__ Easily overheat and perspire
__ Easy blushing of face, chest, neck
__ Frequent urination or bowel movements from nervousness
__ Crave cool drinks

EARTH

__ Heaviness anywhere in body
__ Fatigue
__ Hard to get up in morning
__ Edema (swelling)
__ Muscles tired often
__ Easy bruising and bleeding
__ Bad breath
__ Low appetite
__ Snacking
__ Hypoglycemia
__ Difficulty digesting oily foods
__ Nausea
__ Vomiting
__ Gas/belching
__ Bloating
__ Hemorrhoids
__ Constipation
__ Diarrhea
__ Abdominal pain
__ Indigestion/heartburn
__ Overthinking
__ Crave/avoid sweets

METAL

__ Dry cough
__ Cough with sputum
__ Nasal discharge
__ Poor sense of smell
__Nose bleeds
__ Itchy, red or painful throat
__ Dry mouth
__ Skin rashes, eczema, hives
__ Itchy skin
__ Grief, sadness
__ Shortness of breath
__ Allergies
__ Low resistance to colds/flu
__ Low physical stamina
__ Mild fever comes and goes
__ Runny nose or stuffy sinuses
__ Constant phlegm in chest, throat
__ Easily disappointed or offended
__ Crave/avoid spicy foods

WATER

__ Hearing problems
__ Low back pain/weakness
__ Edema
__ Dark under the eyes
__ Hair thinning or loss
__ Premature aging
__ Poor memory
__ Frequent urination
__ Incontinence
__ Kidney stones
__ Weakness of legs/knees
__ Rapid weight change
__ Low sexual energy
__ Thyroid problems
__ Diabetes
__ Crave/avoid salty foods

WOOD

__ Headaches
__ Migraines
__ Ringing in the ears
__ Poor eye sight
__ Ear infections
__ Dry eyes
__ Blurred vision
__ Herpes simplex
__ Nervousness
__ Convulsion, spasms, cramping
__ Depression
__ Irritability
__ Constipation
__ Hemorrhoids
__ Hepatitis
__ Crave/avoid sour foods

ANY ADDITIONAL COMMENTS: ____

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