Lake Tahoe Wellness Center

# ACUPUNCTURE PATIENT INFORMATION

NAME: _____ Date: _____

Best Phone #: _____ Alternate Phone #: _____

Address: _____ City/ST/Zip: _____

Email_____ May we add you to our mailing list? ☐Yes ☐No

Age: _____ Birth Date: _____ Marital Status:_____ Occupation:_____

EMERGENCY CONTACT/GUARDIAN:_____ Phone: _____

***Referred by***:_____

Insurance Company:_____ Social Security Number:_____

Primary Member:_____ Policy Number:_____

Group Number:_____Provider Customer Service Phone Number:_____

***I give my practitioner permission to bill my insurance company. If my claims are denied, I agree to promptly pay the regular fee per service received. Signature:***_____

Current reason(s) for seeking treatment? _____

What results would you like to obtain? _____

How long have you had this condition? _____ Cause? _____

What makes it better? _____ Worse? _____

Has this condition been diagnosed by an MD? ☐No ☐Yes, Diagnosis: _____

Other professional treatments you are receiving:_____

Other things you are doing to help yourself:_____

**Please list the medications, over-the-counter drugs, and supplements you are currently taking:**

Medication/Supplement: Reason for Taking: Dosage: When Prescribed?

_____

_____

_____

_____

_____

***For your safety, your acupuncturist must know if you have any of the following conditions:***

☐ **Diabetes:** Type 1 / Type 2 (circle) Blood Pressure:☐High ☐Low ☐Lymphedema ☐Anemia

☐Taking Blood Thinners/Coumadin/Warfarin ☐Cancer: _____ ☐Dizziness/Vertigo

☐PACEMAKER ☐Seizures ☐HIV/AIDS ☐Hepatitis A B C ☐Hemophilia ☐High Cholesterol

☐Stroke ☐Ulcer ☐Heart Disease ☐Kidney Disease ☐Thyroid Disease ☐Other:_____

**Women: Date of Last Period _____ Pregnant? ☐No ☐Yes _____ Nursing? ☐ No ☐ Yes**

Anything you wish to add? _____

_____

**The above information is true to the best of my knowledge**. If there is any change to my medical status or medications, I will inform my healthcare provider. I have read/received the Privacy Practices Notice.

***I understand that there is a <u>24-hour cancellation policy</u>, and I may be billed for missed appointments.***

Signature:_____ Date: _____

**Payment is due in full at time of service unless prior arrangements have been approved.**

*PLEASE CHECK ALL SYMPTOMS WHICH BEST DESCRIBE YOUR TENDENCIES IN THE PAST 6 MONTHS, OR SPECIFY WHEN YOU EXPERIENCED THEM. These are significant even if they aren't problematic for you!*

| | BODY TEMPERATURE |
|---|---|
| _____ | Hot Body Temperature (sensation) |
| _____ | Cold Body Temperature (sensation) |
| _____ | Warm at night |
| _____ | Heat in Chest/Face/Palms |
| _____ | Hot Flashes |
| _____ | Cold Hands/Feet |
| _____ | Cold or Heat Sensations with Pain |

| | SWEAT |
|---|---|
| _____ | Profuse Sweat (with little activity) |
| _____ | No Sweat or very little sweat |
| _____ | Spontaneous Sweat (w/out activity) |
| _____ | Night Sweats |
| _____ | Hands/Feet Sweat |
| _____ | Oily Sweat. With odor? Y N |

| | THIRST |
|---|---|
| _____ | Thirsty Regularly |
| _____ | Thirsty with desire for cold drinks |
| _____ | Dry Mouth, Little Thirst |
| _____ | Dry Mouth & Thirst at Night |
| _____ | No Thirst or very little thirst |

| | DIGESTION |
|---|---|
| _____ | Excessive Appetite |
| _____ | Low Appetite |
| _____ | Sudden Weight Gain or Loss |
| _____ | Nausea/Vomiting |
| _____ | Stomach Pain |
| _____ | Hiccoughs |
| _____ | Gas |
| _____ | Bloating |
| _____ | Tired After Eating |
| _____ | Gurgling Sounds |
| _____ | Acid Reflux/GERD |
| _____ | Hiatal Hernia |
| _____ | Ulcers |
| _____ | Heart Burn |
| _____ | Belching |
| _____ | Mouth Sores (canker) |
| _____ | Other:_____ |

| | PREFERRED FLAVORS |
|---|---|
| _____ | Sour/Vinegar |
| _____ | Bitter/Tart |
| _____ | Sweet/Sugary |
| _____ | Pungent/Spicy |
| _____ | Salty |

| | TASTE & MOUTH |
|---|---|
| _____ | Bitter Taste in Mouth |
| _____ | Bland/Tasteless |
| _____ | Mouth Sores (canker) |
| _____ | Tongue Sores/Pain |
| _____ | Bleeding Gums or Gum Disease |
| _____ | Foul Breath |
| _____ | Dry Lips/Mouth |
| _____ | Profuse Saliva |
| _____ | Tooth Problems:_____ |

| | DEFECATION |
|---|---|
| _____ | Daily Bowel Movements: #_____ |
| _____ | Irregular Stools: Every____Days |
| _____ | Alternating Loose/Hard Stool |
| _____ | Constipation |
| _____ | Dry Stool |
| _____ | Hard/Pebbly Stool |
| _____ | Soft/Mushy Stools |
| _____ | Loose Stools |
| _____ | Loose Stool in Morning |
| _____ | Diarrhea |
| _____ | Undigested Food in Stool |
| _____ | Blood or Mucous in Stool |
| _____ | Painful Defecation |
| _____ | Pain after Defecation |

| | URINATION |
|---|---|
| _____ | Frequent |
| _____ | Urgent |
| _____ | Clear/Profuse |
| _____ | Dark Color/Small Amount |
| _____ | Burning/Painful |
| _____ | Cloudy Urine |
| _____ | Incontinence |
| _____ | Stress Incontinence |
| _____ | Nighttime Urination (#_____) |
| _____ | Frequent Bladder Infections |
| _____ | Blood in Urine |
| _____ | Kidney Infections or Stones |

| | STRESS LEVEL |
|---|---|
| _____ | Extremely High |
| _____ | High |
| _____ | Moderate / Normal |
| _____ | Low |
| _____ | Source of Stress:_____ |

| | SLEEP |
|---|---|
| _____ | HOURS PER NIGHT |
| _____ | Good Sleep/Feel Rested |
| _____ | Poor Quality Sleep |
| _____ | Insomnia |
| _____ | Insomnia w/ Restlessness |
| _____ | Difficulty Falling Asleep |
| _____ | Difficulty Staying Asleep |
| _____ | Restless Sleep/Light Sleeper |
| _____ | Intense Dreams |
| _____ | Wake to Urinate, #_____ |
| _____ | Easy back to sleep after waking |
| _____ | Difficult back to sleep after waking |
| _____ | Deep Sleeper / Difficult Waking |
| _____ | Can Sleep All Day |
| _____ | Snoring |

| | ENERGY & STAMINA |
|---|---|
| _____ | High Energy, Good Stamina |
| _____ | Low Energy, Fatigue |
| _____ | Fatigue in the Afternoon |
| _____ | Exhausted After Sex |

| | EMOTIONAL TENDENCIES |
|---|---|
| _____ | Irritability/Anger |
| _____ | Joy/Excitement/Talkativeness |
| _____ | Worry/Over-thinking/Pensiveness |
| _____ | Sadness/Grief/Crying |
| _____ | Fear/Anxiety/Shock |
| _____ | Depressed/Unhappy |
| _____ | Indecisive/Lack of Direction |

| | SENSITIVE TO: (or dislike of...) |
|---|---|
| _____ | Wind |
| _____ | Heat |
| _____ | Dampness/Humidity |
| _____ | Dryness |
| _____ | Cold |
| _____ | Weather Changes |
| _____ | Favorite Season?_____ |

| | HEAD |
|---|---|
| _____ | Headaches, Location:_____ |
| _____ | Migraines |
| _____ | Poor Memory: Long Term or Short |
| _____ | Foggy Mind, Heavy Head |
| _____ | Mental Confusion |
| _____ | Dizziness |
| _____ | Head Injury or Stroke _____ |



**PATIENT SIGNATURE:**_____

*PLEASE CHECK ALL SYMPTOMS WHICH BEST DESCRIBE YOUR TENDENCIES IN THE PAST 6 MONTHS, OR SPECIFY WHEN YOU EXPERIENCED THEM. These are significant even if they aren't problematic for you!*

| | **EARS, EYES, NOSE, THROAT** |
|---|---|
| _____ | Ear Infections |
| _____ | Ear Ringing: High or Low Pitch? |
| _____ | Hearing Loss / Deafness |
| _____ | Ear Congestion or Discharge |
| _____ | Blurred Vision or Vision Impaired |
| _____ | Floaters in Vision/Black Spots |
| _____ | Dim Night Vision |
| _____ | Bloodshot Eyes or Burning Pain |
| _____ | Dry Eyes |
| _____ | Gritty Eyes |
| _____ | Glaucoma |
| _____ | Sinus Congestion |
| _____ | Nasal Discharge: Watery or Thick? |
| _____ | Sinus Infections Chronic |
| _____ | Nosebleeds |
| _____ | Sneezing |
| _____ | Allergies |
| _____ | Speech Problems |
| _____ | Sore Throat |
| _____ | Lump in Throat Sensation |
| _____ | Difficult Swallowing |
| | |
| | **CHEST, HEART, LUNGS** |
| _____ | Difficult Breathing |
| _____ | Shortness of Breath |
| _____ | Cough |
| _____ | Chest Pain |
| _____ | Chest Pain Radiating to Shoulder |
| _____ | Tightness in Chest/Rib/Side |
| _____ | Chest Congestion with Phlegm |
| _____ | Chronic Bronchitis |
| _____ | Frequent Sighing |
| _____ | Asthma |
| _____ | Pneumonia, When?_____ |
| _____ | Breast Distention |
| _____ | Heart Palpitations |
| _____ | Mitral Valve Prolapse |
| _____ | Heart Condition: _____ |
| | |
| | **PAIN, Location:_____** |
| _____ | Since When?_____ |
| _____ | Radiates To:_____ |
| _____ | Sharp/Stabbing Pain |
| _____ | Dull/Achey Pain |
| _____ | Better with Pressure or Exercise |
| _____ | Better with Rest |
| _____ | Better with Heat |
| _____ | Pain Comes and Goes |

| | **BODY & LIMBS** |
|---|---|
| _____ | Tingling Sensations |
| _____ | Numbness, Where?_____ |
| _____ | Pain:_____ |
| _____ | Overall Body Aches |
| _____ | Arms/Legs Feel Heavy |
| _____ | Prolapsed Organs |
| _____ | Tight neck/shoulders |
| _____ | Breast Distention/Tenderness |
| _____ | Swollen Hands/Feet |
| _____ | Easy Broken Bones or Osteoporo |
| _____ | Sore/Weak Knees |
| _____ | Low Back Pain/Weakness |
| _____ | Muscle Spasms or Cramps |
| _____ | Paralysis |
| _____ | Fibromyalgia |
| _____ | Hernia (abdominal) |
| _____ | Stroke |
| _____ | Paralysis |
| _____ | Lupus |
| _____ | Arthritis, Osteo- or Rheumatoid |
| | |
| | **SKIN & HAIR** |
| _____ | Poor Circulation |
| _____ | Varicose Veins |
| _____ | Easy Bruising |
| _____ | Eczema or Hives |
| _____ | Hair Loss or Premature Graying |
| _____ | Brittle Nails |
| _____ | Skin Rashes |
| _____ | Hemorrhoids |
| _____ | Foot Fungus or Nail Fungus |
| _____ | Dry Skin |
| _____ | Acne |
| _____ | Warts |
| _____ | Cold Sores |
| _____ | Frequent Ingrown Hairs |
| _____ | Other:_____ |
| | |
| | **MEN ONLY** |
| _____ | Impotence |
| _____ | Prostate problems |
| _____ | Testicular pain |
| _____ | Testicular swelling |
| _____ | Cold/numb in genital area |
| _____ | Low Libido |
| _____ | High Libido |
| _____ | Premature Ejaculation |
| _____ | Other:_____ |

| | **WOMEN ONLY** |
|---|---|
| | Age at 1st period:_____ |
| | Age at menopause:_____ |
| _____ | Pregnant? _____ |
| _____ | Nursing? |
| _____ | Birth Control?_____ |
| | # of children:_____ |
| | Ages_____ |
| | |
| _____ | Abortions |
| _____ | Miscarriages: #_____ |
| _____ | Infertility, Since:_____ |
| _____ | Hysterectomy, _____ |
| _____ | Menopause Symptoms:_____ |
| | |
| _____ | # days of Flow |
| _____ | # days of Cycle |
| | |
| _____ | Heavy periods |
| _____ | Light periods |
| _____ | Painful periods |
| _____ | Irregular periods |
| _____ | Bleeding Between Periods |
| _____ | Clots |
| _____ | Dark Blood |
| _____ | Watery/Light color blood |
| _____ | Mucous with blood |
| _____ | Cramps Before Period |
| _____ | Cramps During Period |
| _____ | PMS |
| _____ | Pain/Achey after periods |
| _____ | Breast Tenderness |
| _____ | Fatigue During Period |
| _____ | Vaginal discharge (Circle Below) |
| _____ | Yellow, White, or Red/White? |
| | |
| _____ | Low Libido |
| _____ | High Libido |
| _____ | Fibroids |
| _____ | Endometriosis |
| _____ | Ovarian Cysts or PCOS |
| _____ | OTHER:_____ |
| | |
| | **HOSPITALIZATIONS/SURGERIES** |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |



**PATIENT SIGNATURE:**_____