Asian Healing Arts

acupuncture | herbal therapies | massage

Patient Information

Name_____Date_____

Address_____ City_____ State_____

Zip_____ Home Phone_____ Work Phone_____ Cell_____

Email_____ Have You Had Acupuncture Before? ☐ Yes ☐ No

Height_____ Weight_____ Age_____ Sex: ☐ Male ☐ Female Date of Birth_____

Occupation_____ Employer_____

Emergency Contact Name_____ Emergency Phone Number_____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Separated

Number of Children: _____ Ages of Children:_____ Number Who Live With You:_____

Other's Living With You: _____

Primary Care Doctor: _____ Last Seen: _____

How did you hear about AHAA? ☐ Yellow Pages ☐ New Vision Ad ☐ Article ☐ A Talk ☐ Brochure ☐ Business Card ☐ Website ☐ New Times Ad ☐ Referred By: _____

Medical History

Reason for your visit here today? _____

_____

Are you being treated for this condition by anyone else? ☐ Yes ☐ No

If yes, who? _____ Phone Number: _____

Has this condition been diagnosed by a MD? ☐ Yes (Diagnosis: _____) ☐ No

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not Much ☐ No

How does this condition affect you? _____

How long have you had this condition? _____

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly

If yes, please identify: ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Flu/Cold ☐ Streptococcus ☐ Mononucleosis ☐ Tuberculosis ☐ Other: _____

Known or suspected allergies: _____

Childhood diseases you have had: ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rheumatic Fever ☐ Diphtheria ☐ Scarlet Fever ☐ Other_____

Accidents/Hospitalizations/Surgeries in the past 10 years:

Reason Date

_____
_____
_____
_____

Your general health as a child: ☐ Excellent ☐ Good ☐ Average ☐ Poor

Health Inventory

Cardiovascular Conditions:	Emotional/Mental:	Energy & Immunity:	Respiratory:
☐ Heart Disease ☐ Pacemaker ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Pain ☐ Palpitations ☐ Stroke ☐ Varicose Veins ☐ Edema	☐ Clinical Depression ☐ Mild Depression ☐ ADD or ADHD ☐ Schizophrenia ☐ Mood Swings ☐ Panic Attacks ☐ Nervousness ☐ Anxiety ☐ Alzheimer's ☐ Dementia	☐ Chronic Fatigue Syndrome ☐ General Fatigue ☐ Slow Wound Healing ☐ Easy Bruising ☐ Chronic Infections ☐ Frequent Allergies	☐ Pneumonia ☐ Asthma ☐ Frequent Common Colds ☐ Difficulty Breathing ☐ Emphysema ☐ Persistent Cough ☐ Pleurisy ☐ Tuberculosis ☐ Shortness of Breath
Musculo-Skeletal:	**Head, Eye, Ear, Nose & Throat**	**Genito-Urinary Tract:**	**Gastrointestinal:**
☐ Neck/Shoulder Pain ☐ Muscle Spasms/Cramps ☐ Arm Pain ☐ Upper Back Pain ☐ Mid Back Pain	☐ Impaired Vision ☐ Eye Pain/Strain ☐ Glaucoma ☐ Glasses/Contacts ☐ Tearing/Dryness	☐ Kidney Disease ☐ Kidney Stones ☐ Painful Urination ☐ Dribbling Urination ☐ Frequent UTI ☐ Frequent Urination	☐ Stomach Ulcers ☐ Changes in Appetite ☐ Nausea/Vomiting ☐ Epigastric/Abdominal Pain ☐ Passing Gas

☐ Low Back Pain ☐ Leg Pain ☐ Osteoporosis ☐ Arthritis ☐ Joint Pain	☐ Impaired Hearing ☐ Ear Ringing ☐ Earaches ☐ Ear Infections ☐ Headaches ☐ Sinus Problems ☐ Nose Bleeds ☐ Teeth Grinding ☐ Frequent Sore Throats ☐ TMJ/Jaw Problems ☐ Hay Fever	☐ Blood in Urine ☐ Discharge ☐ Incontinence	☐ Heart Burn ☐ Belching ☐ Gall Bladder Disease ☐ Gall Bladder Stones ☐ Hemorrhoids ☐ Constipation ☐ Diarrhea
Neurological: ☐ Vertigo/Dizziness ☐ Paralysis ☐ Numbness/Tingling ☐ Loss of Balance ☐ Seizures/Epilepsy ☐ Dyslexia	Endocrine: ☐ Hypothyroid ☐ Hypoglycemia ☐ Hyperthyroid ☐ Diabetes Type I ☐ Diabetes Type II ☐ Night Sweats ☐ Unusual Sweating ☐ Feeling Hot or Cold	Liver Conditions: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C	Other: ☐ Cancer Type: _____ ☐ Fibromyalgia ☐ Lupus ☐ Candida ☐ Anemia ☐ Rashes ☐ Eczema/Hives ☐ Cold Hand/Feet ☐ Hemophilia ☐ Thin/Graying Hair

Men Only:

- ☐ Impotence
- ☐ Vasectomy Date_____
- ☐ Prostate Problems
- ☐ Testicular Pain/Redness/Swelling
- ☐ Low Libido
- ☐ Excessive Libido
- ☐ Painful Intercourse
- ☐ Seminal Emissions

Women Only:

Are you Pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe Method of Birth Control: _____

Age of First Period: _____ Date of Last Menses: _____ Age at Menopause: _____

Typical Length of Menses (Days): ____ Typical Length of Cycle (From 1st Day to 1st Day of Menses) _____

Number of: Pregnancies: ____ Births: ____ Abortions: ____ Miscarriages: ____

Hysterectomy: ☐ Yes ☐ No Date:_____

Check all that Apply: ☐ Low Libido ☐ Excessive Libido ☐ Painful Intercourse ☐ Clotting

☐ Painful Periods ☐ Heavy Flow ☐ Scanty Flow ☐ Bleeding Between Cycles

☐ Irregular Cycles ☐ Vaginal Discharge ☐ Breast Lumps/Tenderness ☐ Nipple Discharge

☐ Infertility ☐ Menopausal Symptoms ☐ Premenstrual Problems

Medications

Please list all the prescriptions and over the counter medications you are currently taking:

Drug Name Reason for Taking For How Long Dose Frequency

_____
_____
_____
_____
_____
_____

Please list all the supplements and herbs you are currently taking:

Supplement Reason for Taking Potency Frequency

_____
_____
_____
_____
_____
_____

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: ☐ Yes ☐ No Amount: _____ Alcohol: ☐ Yes ☐ No Amount: _____

Coffee: ☐ Yes ☐ No Amount: _____ Recreational Drugs: ☐ Yes ☐ No Amount: _____

Do you feel you are at or near your ideal weight? ☐ Yes ☐ No

Do you feel you have enough energy? ☐ Yes ☐ No Are you a vegetarian or vegan? ☐ Yes ☐ No

Best time of day: _____ Worst time of day: _____

Favorite Season: _____ Hours of Sleep/Night: _____

Do you feel rested after a night's sleep? _____ Do you remember your dreams? _____

Typical Day's Meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Other: _____

Food Cravings: _____

Religion or Other Spiritual Practice: _____

Hobbies or Other Recreation: _____

What kind of physical exercise do you do regularly? _____

Hours of television watched per week? _____ Hours of work per week? _____

Highest level of education completed? ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other

How would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

Emotions/Relationships

Number of biological brothers: _____ Sisters: _____ Were you adopted? ☐ Yes ☐ No

Your place in the birth sequence #: _____

Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What would you characterize as your predominate emotion right now? ☐ Anxiety/Worry ☐ Anger ☐ Grief ☐ Fear/Dread ☐ Depression ☐ Melancholy ☐ Happiness ☐ Contentment ☐ Joy ☐ Numbness/Apathy ☐ Other: _____

Do you enjoy your work? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Do you feel safe in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

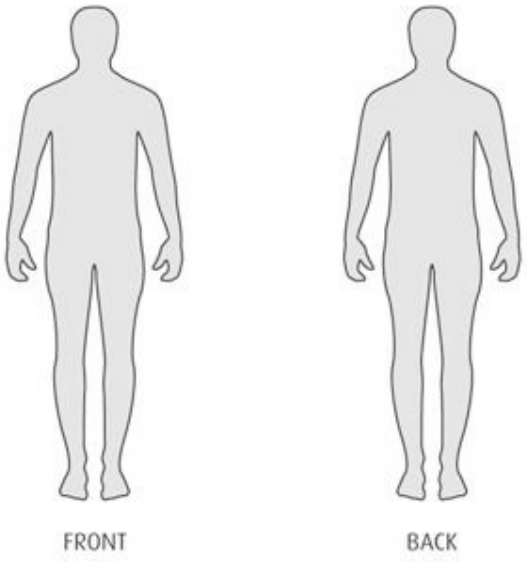
Do you feel nurtured in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you happy with your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you satisfied with your sex life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

If you were guaranteed success and money and time were not obstacles, what would you do with your life?

_____
_____
_____
_____



Please feel free to express any concerns or thoughts you feel may be relevant to your health below:

(Use the diagram if desired)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The information above is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I understand and accept that I am expected to notify AHAA 24 hours prior to any cancellations or changes to my appointment times and if I do not I may be charged for the appointment.

Signed: _____ Date: _____

Parent/Guardian (if applicable) _____

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Ear Diagram for Medical Use Only:

Left Ear	Right Ear