The Present Sage Acupuncture

New Patient Health History

THIS INFORMATION IS CONFIDENTIAL

Name _____ Date _____/_____/_____

Address _____ City_____ State_____ Zip_____

Date of birth _____/_____/_____ Age_____ Height_____ Weight _____ lbs

Telephone: Home _____ Cell _____ Work_____

Email _____ Best way(s) to contact you: ☐Home ☐Cell ☐Work ☐Email

Occupation:_____ Marital Status:_____

Primary care physician name and telephone: _____

Emergency contact name and telephone _____

Referred by: _____ May we thank him or her? _____

Please list any other medical providers that you are currently seeing for care:

☐ Chiropractor _____ ☐ Specialist _____

☐ Nutritionist _____ ☐ Therapist _____

☐ Gynecologist_____ ☐ Naturopath _____

☐ Physical Therapist _____ ☐ Other _____

Primary reason for seeking acupuncture treatment:

What are your treatment goals? _____

_____

What makes your condition better? (Rest, movement, certain foods, heat, cold, fresh air, emotional expression, etc.)

_____

What makes it worse? (Overwork, fatigue, emotional suppression, hunger, heat, certain foods, damp days etc.)

_____

What, if anything, has been diagnosed (by your M.D.)?

_____

General health and wellbeing

Please check if you have had any of the items listed below in the last year.
Put a P in the box if you had this item in the past but no longer have it.

- ☐ Fatigue
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Sweats Easily
- ☐ Poor sleeping
- ☐ Bleed/bruise easily
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight loss/gain
- ☐ Cravings
- ☐ Strong thirst (hot or cold drinks)
- ☐ Peculiar tastes/smells
- ☐ Dental/gum problems
- ☐ Muscle weakness/fatigue
- ☐ Localized weakness
- ☐ Poor balance
- ☐ Tremors
- ☐ Sudden energy drop

Skin and hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Hives/Allergic Dermatitis
- ☐ Acne
- ☐ Eczema/Psoriasis
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Fungal Infection
- ☐ Weak nails

Head, eyes, ears, nose and throat

- ☐ Recurrent sore throats/colds
- ☐ Headaches
- ☐ Migraines
- ☐ Sinus problems
- ☐ Dizziness
- ☐ Poor vision
- ☐ Eye pain
- ☐ Cataracts
- ☐ Spots in front of eyes
- ☐ Night Blindness
- ☐ Nose bleeds
- ☐ Dental problems
- ☐ Jaw clicks/locks
- ☐ Sores on lips/tongue
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Difficulty swallowing
- ☐ Grinding teeth

Cardiovascular

- ☐ Palpitations
- ☐ Fast pulse (over 100 beats/minute)
- ☐ Slow pulse (less than 60 beats/minute)
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Pain or pressure in chest
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Fainting
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Swelling of hands/feet
- ☐ Cold hands/feet
- ☐ Cold sweats
- ☐ Phlebitis
- ☐ Anemia

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Check the box if you have had any of the items listed below in the last year.

Please put a **P** in the box if you had this symptom **in the past** but no longer have it.

Respiratory

- ☐ Cough/Wheezing
- ☐ Asthma
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Difficulty inhaling/exhaling
- ☐ Tight sensation in chest
- ☐ Production of phlegm

Gastrointestinal

- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Diarrhea
- ☐ Loose stools
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Belching
- ☐ Bloating
- ☐ Intestinal gas
- ☐ Heartburn
- ☐ Nausea or vomiting
- ☐ No appetite
- ☐ Excessive appetite
- ☐ Significant thirst
- ☐ Bad breath
- ☐ Hemorrhoids
- ☐ Pancreatitis
- ☐ Illeocecal valve syndrome
- ☐ GI tumors
- ☐ IBS/Crohn's Disease
- ☐ Polyps
- ☐ Ulcers
- ☐ Peritonitis

Neuropsychological & emotional

- ☐ Nervousness
- ☐ Anxiety/panic attacks
- ☐ Depression
- ☐ Easily irritated
- ☐ Frequent emotional "ups and downs"
- ☐ Hopelessness
- ☐ Easily susceptible to stress
- ☐ Seasonal Affective Disorder
- ☐ Substance Abuse
- ☐ Vertigo/Dizziness
- ☐ Headaches
- ☐ Concussion
- ☐ Seizures

Urinary

- ☐ Infections
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Scanty flow
- ☐ Burning urination
- ☐ Urinary tract infection
- ☐ Decreased libido
- ☐ Excessive libido
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Pain on urination
- ☐ Copious flow
- ☐ Night urination
- ☐ Sores on genitals
- ☐ Kidney stones
- ☐ Herpes

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain lower/middle/upper
- ☐ Shoulder pain
- ☐ Rotator Cuff
- ☐ Hand/wrist pain
- ☐ Carpal Tunnel
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Sciatica

Other: _____

- ☐ Bursitis
- ☐ Tendonitis
- ☐ Muscle pain
- ☐ Muscle weakness

Indicate what side of body or bilateral:

_____

Male sexual health

- ☐ Prostatitis
- ☐ Lumps n testicles
- ☐ Pain/Itching of genitalia
- ☐ Pain in testicles
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Impotence

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Please check if you have had any of the items listed below in the last year.
Put a P in the box if you had this item in the past but no longer have it.

Female gynecological/reproductive

- ☐ Age of first menses _____
- ☐ Date of last menses _____
- ☐ PMS
- ☐ Irregular menstruation
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Uterine Fibroids
- ☐ Polycystic Ovarian Disease
- ☐ Endometriosis or Adenomyosis
- ☐ Difficult/painful intercourse
- ☐ Date of last PAP/Pelvic exam _____
- ☐ Infertility
- ☐ Menopausal or perimenopausal symptoms

Medical history

Illnesses, surgeries, accidents

Childhood:

_____ age ___ _____ age ___ _____ age ___

Adolescence:

_____ age ___ _____ age ___ _____ age ___

Adulthood:

_____ age ___ _____ age ___ _____ age ___

Do you have any physical **scars**? Note location of *all* scars from operations or injuries (including minor ones.)

_____

Family medical history Please check any condition that applies to your family and list family member.

- ☐ Diabetes_____
- ☐ Heart Disease_____
- ☐ Asthma_____
- ☐ Cancer_____
- ☐ Emotional disorder_____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Allergies_____
- ☐ High Blood Pressure _____
- ☐ Neurological disorder_____

Other: _____

Medical diagnoses Please check any conditions or symptoms you currently have.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Raynaud's Disease
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Stroke
- ☐ Hepatitis
- ☐ Anemia
- ☐ Hypo/Hyperglycemia
- ☐ Food Allergies/Intolerance
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Diverticulitis/IBS
- ☐ Ulcer
- ☐ Respiratory Allergies
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Fatigue
- ☐ Lyme Disease/Tick-borne illness
- ☐ Chronic Pain Condition
- ☐ Intestinal parasites

Medical diagnoses (cont.) Please check any conditions or symptoms you currently have.

☐ Alcoholism	☐ Diabetes	☐ Impotence
☐ Kidney Disease	☐ Thyroid Imbalance	☐ Chronic Fatigue
☐ Cancer	☐ Seizures	☐ Fibromyalgia
☐ Essential tremor	☐ HIV/AIDS	

Other: _____

_____

Medications Please list all medications, vitamins, and/or food supplements you are currently taking.

Medication _____ Dosage _____ For what condition? _____

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Medication _____ Dosage _____ For what condition? _____

Vitamins _____

Food Supplements _____

Allergies or reactions to medications: _____

Health maintenance screening tests

☐ Lipid (cholesterol) Date _____ Abnormal? _____

☐ Sigmoidoscopy or ☐ Colonoscopy Date _____ Abnormal? _____

Women

☐ Mammogram Date_____ Abnormal?_____

☐ Pap Smear Date_____ Abnormal?_____

☐ Dexascan (osteoporosis) Date_____ Abnormal?_____

Men

☐ PSA (prostate) Date_____ Abnormal?_____

Lifestyle

For each item below, indicate how much, how many, or how often if applicable. Indicate whether this is a current habit or provide the date that you quit.

Cigarettes (packs per day) _____ **Coffee/Tea** (cups per day) _____

Alcohol (drinks per week) _____ **Soda** (regular or diet) _____

Drug use (recreational) _____

Exercise ☐ Yes ☐ No Type of exercise(s) _____

How often? _____ If you don't exercise, what prevents you?_____

Meditation ☐ Yes ☐ No How often? _____

Diet

Please indicate if your diet is:

☐ Vegetarian ☐ Vegan ☐ Gluten-Free ☐ Primarily organic ☐ Special dietary restrictions

Typical Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Overall energy level (rate from 1-10) _____ Is this better or worse than your experience of energy levels in the past? (please comment) _____

Menstrual cycle

Amount of flow (normal, heavy, light)_____

Length of cycle _____ Clotting (large, small, black, purple, red, other) _____

Cramps:(dull or sharp, location) _____

☐ Breast tenderness ☐ Cravings ☐ Mood swings ☐ Anger/frustration ☐ Headaches

Do you practice birth control? _____ What type?_____ How long?_____

Number of live births _____ Number of miscarriages _____

Please indicate if the miscarriage took place during the **first, second, or third trimester(s).**

Additional information

Is there anything else you would like us to know or any questions you have about your treatment?

_____

_____

_____

_____ _____

Patient Signature **Date**