2432 W. Peoria Ave.
Suite 1029
Phoenix, AZ 85029
(480) 437-0532

Confidential Patient Information Sheet 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_____
In emergency notify (name): _____

Emergency phone number: _____

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

Separated Number of children: _____ Ages of children: _____

Number who live with you: Others living with you:_____

Primary Care Doctor _____Last seen:_____

How did you hear about Total Wellness Acupuncture: ☐ Internet ☐ Brochure ☐

Business Card ☐ Web site ☐ Referred by:

Medical History

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 _____

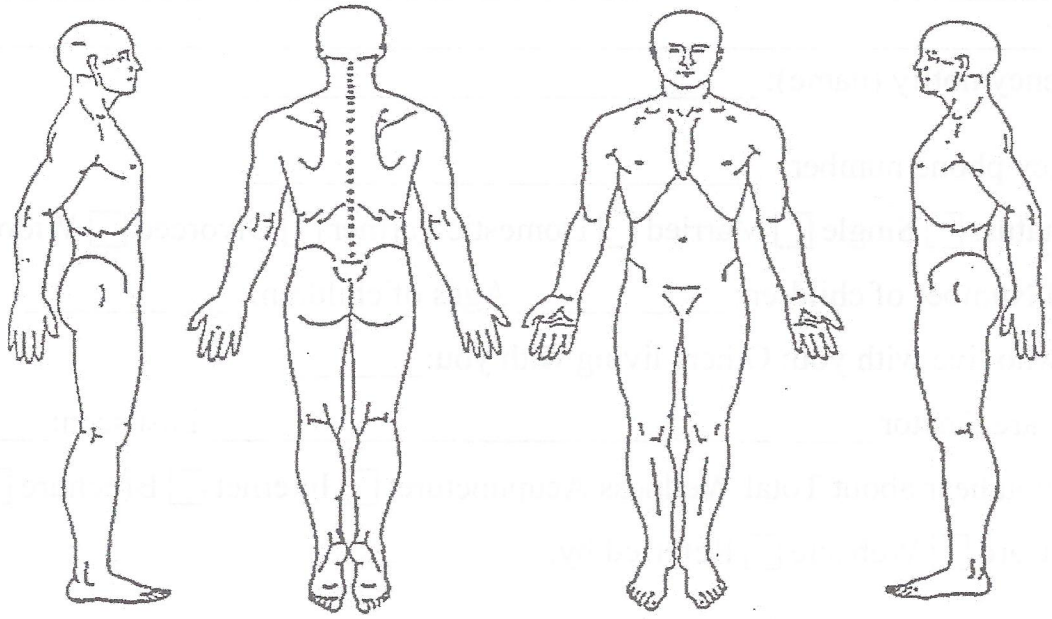
Accidents / Hospitalizations / Surgeries in the past 10 years:

Reason Date / Year(s) _____

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

Please indicate any painful or distressed body areas by circling the particular area:

by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

Cardiovascular Conditions:	**Emotional / Mental**:	**Energy & Immunity**:	**Respiratory**:
☐ Heart Disease	☐ Clinical Depression	☐ Chronic Fatigue Syndrome	☐ Pneumonia
☐ A Pacemaker	☐ Mild Depression	☐ General Fatigue	☐ Asthma
☐ High Blood Pressure	☐ ADD or ADHD	☐ Slow Wound Healing	☐ Frequent Common Colds
☐ Low Blood Pressure	☐ Schizophrenia	☐ Easy Bruising	☐ Difficulty Breathing
☐ Chest Pain	☐ Mood Swings	☐ Chronic Infections	☐ Emphysema
☐ Palpitations	☐ Panic Attacks	☐ Frequent Allergies	☐ Persistent Cough
☐ Stroke	☐ Nervousness		☐ Pleurisy
☐ Varicose Veins	☐ Anxiety		☐ Tuberculosis
☐ Edema	☐ Alzheimer's		☐ Shortness of Breath
	☐ Dementia		

Musculo-Skeletal:	**Head, Eye, Ear, Nose & Throat**:	**Genito-Urinary Tract**:	**Gastrointestinal**:
☐ Neck / Shoulder Pain	☐ Impaired Vision	☐ Kidney Disease	☐ Stomach Ulcers
☐ Muscle Spasms / Cramps	☐ Eye Pain/Strain	☐ Kidney Stones	☐ Changes in Appetite
☐ Arm Pain	☐ Glaucoma	☐ Painful Urination	☐ Nausea / Vomiting
☐ Upper Back Pain	☐ Glasses / Contacts	☐ Dribbling Urination	☐ Epigastric / Abdominal Pain
☐ Mid Back Pain	☐ Tearing / Dryness	☐ Frequent UTI	☐ Passing Gas
☐ Low Back Pain	☐ Impaired Hearing	☐ Frequent Urination	☐ Heart Burn
☐ Leg Pain	☐ Ear Ringing	☐ Blood in Urine	☐ Belching
☐ Osteoporosis	☐ Earaches	☐ Discharge	☐ Gall Bladder Disease
☐ Arthritis	☐ Ear Infections	☐ Incontinence	☐ Gall Bladder Stones
☐ Joint Pain	☐ Headaches		☐ Hemorrhoids
	☐ Sinus Problems	**Neurological**:	☐ Constipation
	☐ Nose Bleeds	☐ Vertigo / Dizziness	☐ Diarrhea
	☐ Teeth Grinding	☐ Paralysis	
	☐ Frequent Sore Throats	☐ Numbness / Tingling	
	☐ TMJ / Jaw Problems	☐ Loss of Balance	
	☐ Hay Fever	☐ Seizures / Epilepsy	
		☐ Dyslexia	

Endocrine:	**Other**:	**Liver Conditions**:	**Men Only**:
☐ Hypothyroid	☐ Cancer Type:_____	☐ Hepatitis A	☐ Impotence
☐ Hypoglycemia	☐ Fibromyalgia	☐ Hepatitis B	☐ Vasectomy Date: _____
☐ Hyperthyroid	☐ Lupus	☐ Hepatitis C	☐ Prostate problems
☐ Diabetes Type I	☐ Candida		☐ Testicular Pain / Redness / Swelling
☐ Diabetes Type II	☐ Anemia		☐ Low libido
☐ Night Sweats	☐ Rashes		☐ Excessive libido
☐ Unusual Sweating	☐ Eczema / Hives		☐ Painful Intercourse
☐ Feeling Hot or Cold	☐ Cold Hand / Feet		☐ Seminal emissions
	☐ Hemophilia		
	☐ Thin / Graying hair		

Women Only:

Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe

Method of Control_____

Age at 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

Mediactions

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

Drug Name	Reason for taking	For how long	Dose Frequency

Please list all supplements and herbs you are currently taking:

Supplement	Reason for taking	Potency	Frequency

Life Style

(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 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 nights 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 to 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 /Relationship

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

Why or why not? _____

Do you love where you live? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? _____

Do you feel you have a higher purpose for your life? ☐ 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 ☐ Nev

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 of success and money and time were not obstacles, what would you like to do with your life?_____

_____

The above information 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 also understand and accept that I am expected to notify Total Wellness Acupuncture 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: _____ Date:

Parent / Guardian (if applicable)

_____

Would you like to receive a free email newsletter? ☐ Yes ☐ No