

Havertown Community Acupuncture
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610-789-1120

Confidential Patient Information Sheet

Name _____ Date _____
Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____ Have you had acupuncture before? Yes No

Occupation _____ Age _____ Date of birth _____ In emergency notify (name): _____
Emergency phone number _____

Marital Status: Single Married Domestic Partner Divorced Widowed Separated

Primary Care Doctor _____ Last seen _____

How did you hear about us: Facebook Brochure/Business Card Website/Social Media Other

Referred by _____

Primary reason(s) for your visit here today:

1. _____

2. _____

3. _____

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 Not at all

How does this condition affect you?

How long have you had this condition? _____

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:

Type Reason Date

Your general health as a child: Excellent Good Average Poor

Father Overall Health Good Poor Age ____ If deceased, Cause of death _____

Mother Overall Health Good Poor Age ____ If deceased, Cause of death _____

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

Drug Name Reason for taking Dose Frequency

Please list all supplements and herbs you are currently taking:

Supplement Reason for taking Potency Frequency

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? _____

Food cravings: _____

What kind of physical exercise to you do regularly?

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

Are you looking for Support for Working on Addictive Habits (Food, Caffeine, Alcohol, Drugs, etc.) _____

Major Life Events (Move, New Job, Loss of Job, Relationship Change) _____

Cardiovascular**Conditions:**

- Heart Disease
- Blood Clots
- Pacemaker
- High Blood Pressure
- Low Blood Pressure
- Fainting
- Chest Pain
- Palpitations
- Stroke
- Varicose Veins
- Edema

Emotional / Mental:

- Clinical Depression
- Mild Depression
- ADD or ADHD
- Schizophrenia
- Mood Swings
- Panic Attacks
- Nervousness
- Anxiety
- High Stress Level
- Alzheimer's
- Dementia

Energy & Immunity:

- Chronic Fatigue Syndrome
- General Fatigue
- Slow Wound Healing
- Easy Bruising
- Chronic Infections
- Frequent Allergies

Respiratory:

- Pneumonia
- Asthma
- Frequent Common Colds
- Difficulty Breathing
- Emphysema
- Persistent Cough
- Pleurisy
- Tuberculosis
- Shortness of Breath

Musculo-Skeletal:

- Neck / Shoulder Pain
- Muscle Spasms/Cramps
- Muscle Weakness
- Arm Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Leg Pain/Sciatica
- Osteoporosis
- Broken Bones
- Arthritis
- Joint Pain

Head, Eye, Ear, Nose & Throat:

- Impaired Vision
- Eye Pain/Strain
- Glaucoma
- Glasses / Contacts
- Tearing / Dryness
- Impaired Hearing
- Head Injury
- Ear Ringing
- Earaches
- Ear Infections
- Headaches
- Migraines
- Sinus Problems
- Nose Bleeds
- Loss of Smell
- Teeth Grinding
- Frequent Sore Throats
- Goiter
- Hoarseness
- Swollen Glands
- Trouble Swallowing
- TMJ / Jaw Problems
- Hay Fever

Genito-Urinary Tract:

- Kidney Disease
- Kidney Stones
- Painful Urination
- Dribbling Urination
- Frequent UTI

- Frequent Urination
- Blood in Urine
- Discharge
- Incontinence

Neurological:

- Vertigo / Dizziness
- Paralysis
- Numbness / Tingling
- Loss of Balance
- Seizures / Epilepsy
- Dyslexia

Gastrointestinal:

- Stomach Ulcers
- Changes in Appetite
- Nausea/Vomiting
- Epigastric/Abdominal Pain
- Passing Gas
- Internal Cramping
- Heart Burn
- Belching
- Gall Bladder Disease
- Gall Bladder Stones
- Hemorrhoids
- Constipation
- Diarrhea
- Loose Stools

Endocrine:

- Hypothyroid
- Hypoglycemia
- Hyperthyroid
- Diabetes Type I
- Diabetes Type II
- Night Sweats
- Unusual Sweating
- Feeling Hot or Cold

Other:

- Cancer
- Type: _____
- Fibromyalgia
- Lupus
- Other Autoimmune Disease _____

- Candida
- Anemia
- Itching/Rashes
- Acne
- Acute Hair Loss
- Eczema / Hives
- Cold Hand / Feet
- Hemophilia
- Thin / Graying hair

Liver Conditions:

- Hepatitis A, B, or C

Men Only

- Impotence
- Erection Difficulties
- Vasectomy
- Date: _____
- Prostate problems
- Testicular Pain / Redness / Swelling
- Low libido
- Excessive libido
- Seminal emissions
- Painful Intercourse

Women Only

- Yes I am pregnant
- Maybe I am pregnant
- No I am not pregnant

Method of Birth Control: _____

Age at first period: _____

Date of last menses: _____

Age at menopause: _____

Typical length of cycle (days): _____

Number of:

Pregnancies: _____

Births: _____

Miscarriages: _____ Hysterectomy:

Yes No Date: _____

Check all that apply

- Clotting
- Painful Periods
- Heavy Flow
- Scanty Flow
- Bleeding Between Cycles
- Irregular Cycles
- Vaginal Discharge
- Breast Lumps / Tenderness
- Nipple Discharge
- Infertility
- Difficulty Conceiving
- Menopausal Symptoms
- Fibroids/Ovarian Cysts
- Premenstrual Problem

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

X _____

The information on pages 1 - 4 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 Havertown Community 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.

Signed: _____

Date: _____

Parent / Guardian (if applicable) _____