Havertown Community Acupuncture
14 E. Eagle Rd. Havertown, PA 19083
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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

Biological Father Overall Health ☐ Good ☐ Poor ☐ Unknown Age ____ If deceased, Cause of death______________

Biological Mother Overall Health ☐ Good ☐ Poor ☐ Unknown 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:
- ☐ 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 CommonColds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Muscular/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
- ☐ Looses 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:
☐ Hepatitis A, B, or C

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

Fertility:
☐ 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.
*I also understand and consent to being treated in a community setting which means that other people will be in the same room as I am when being treated.

Signed:
____

Date: _______________

Parent / Guardian (if applicable)

____