ACUPUNCTURE GREENPOINT

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Please complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but play a major role in your diagnosis and treatment with traditional medicine.

All information is strictly confidential.

Name: _____ Date: ____/____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Date of Birth: ____/____/_____ Age: _____ Gender: _____

Join our email list? (less than 5 per year) _____ How did you hear about us? _____

Emergency contact: _____ Phone: _____

Please list your reason(s) for treatment, in order of importance: _____

_____

Chronic health issues / surgeries / hospitalizations: _____

_____

Current medications / vitamins / other supplements: _____

_____

SLEEP

Hours per night (average): _____ Time to bed: _____ Time to rise: _____

- ☐ Unrested in the morning
- ☐ Difficulty falling asleep
- ☐ Waking during the night
- ☐ Waking to urinate
- ☐ Vivid dreams
- ☐ Night sweats

LIFESTYLE

Occupation: _____ How many hours do you work per week? _____

How is your general energy level? _____ Stress level? _____

Type(s) of exercise: _____ How often? _____

DIET

Dietary restrictions: _____ Cravings: _____

Allergies (medicines/foods/seasonal): _____

- ☐ Poor appetite
- ☐ Irregular meals
- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Inconsistent bowel movements
- ☐ Hard/dry stool
- ☐ Mucous/blood in stool
- ☐ Frequent gas
- ☐ Bloating
- ☐ Frequent belching
- ☐ Acid reflux

MENTAL / EMOTIONAL

- ☐ Poor memory
- ☐ Difficulty concentrating
- ☐ Frustration
- ☐ Anxiety
- ☐ Depression
- ☐ Ruminative thoughts
- ☐ Irritability
- ☐ Crying easily
- ☐ Psycho-emotional disorder(s)

OTHER

Pain & headaches (location/duration): _____

_____

Ears/eyes/nose/throat: _____

Immune system: _____

Skin & hair: _____

- ☐ Addiction
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Hypertension/Hypotension
- ☐ Infectious disease(s)
- ☐ Seizures
- ☐ STD
- ☐ Stroke
- ☐ Thromophilia (blood clots)
- ☐ Thyroid disease
- ☐ Other: _____

FOR WOMEN

Are you, or is there a chance you are pregnant? _____ If so, how far along? _____

- ☐ Bleeding/pain between periods
- ☐ Bleeding/pain during sex
- ☐ Vaginal discharge
- ☐ Yeast infections
- ☐ Cramping before period
- ☐ Cramping during period
- ☐ Cramping after period
- ☐ Increased/decreased libido

Do you experience any of the following **premenstrual symptoms**?

- ☐ Bloating
- ☐ Change in appetite
- ☐ Loose stool
- ☐ Constipation
- ☐ Breast tenderness
- ☐ Irritability
- ☐ Easily upset
- ☐ Migraines

Please list any gynecological surgeries, tests, or any other notable information: _____

_____

FOR MEN

Have you every had a prostate exam? _____ If so, were the results normal/abnormal? _____

- ☐ Prostate issues
- ☐ Rectal dysfunction
- ☐ Back/groin/testicular pain
- ☐ Delayed stream
- ☐ Increased/decreased libido
- ☐ Incontinence/urine retention
- ☐ Dribbling
- ☐ Impotence
- ☐ Premature ejaculation

I understand I am required to advise my acupuncturist of any medical conditions, including pregnancy, which may prevent me from receiving acupuncture.

_____	_____	____/____/_____
Patient's Name - Print	Patient's Signature	Date

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FOR FACIAL REJUVENATION PATIENTS ONLY

Are you currently experiencing, or have you had any of the following?

- ☐ Unmanaged diabetes
- ☐ Thrombocytopenia (bruising/bleeding)
- ☐ Thrombophilia (blood clots)
- ☐ Severe migraines
- ☐ Unmanaged hypertension
- ☐ Contagious skin disease
- ☐ Botox injections
  If yes, where & when?_____
  _____
- ☐ Plastic surgery
  If yes, what surgery & when?_____
  _____

Are you currently taking any of the following medications?

- ☐ Corticosteroids (long term use)
  If yes, for how long?_____
  _____
- ☐ Anticoagulants (blood thinners)
- ☐ Anti-platelet drugs (blood thinners)

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_____	_____	____/____/_____
Patient's Name - Print	Patient's Signature	Date