Alpenglow Acupuncture LLC

Patient Name

Constitutional Symptoms

- □ General health the past year □ Good □ Poor
- \Box Recent weight change
- □ Fever
- □ Fatigue / Poor Energy
- □ Sleep problems / snoring

Eyes

- \Box Eye disease or injury
- □ Wear glasses or contacts
- □ Eye Surgery
- □ Blurred or double vision

Ear/Nose/Mouth/Throat

- Hearing loss or ringing of ears □ Ear pain or drainage □ Ear Infections □ Sinus Infections / Problems □ Nose bleeds □ Mouth sores □ Bleeding gums □ Bad breath or bad taste □ Sore throat or voice change
- □ Swollen glands in neck

Cardiovascular

- □ Last cholesterol screen Date _____ Total LDL HDL Triglycerides □ Heart trouble / attack □ Chest pain / angina □ Heart medications
- □ Blood thinner medications
- □ Heart Murmur
- □ High blood pressure
- □ Shortness of breath walking
- \Box Pain in legs with walking
- □ Shortness of breath at rest
- \Box Swelling of feet or ankles
- □ Varicose veins
- □ Cold Extremities

Respiratory

- Couah
- □ Shortness of breath
- □ Wheezing / Asthma
- □ Inhaler use
- □ Coughing up blood
- □ Tobacco use or exposure

Gastrointestinal

- □ Colon cancer screen Date: □ Appetite □ Good □ Poor □ Excessive □ Change in appetite recently
- □ Nausea or vomiting
- □ Heartburn / Reflux
- □ Abdominal Pain
- □ Bloating
- □ Fatigue after eating
- □ Bowel movements:
- □ Skip days of moving bowels
- □ Constipation
- □ Loose stool or diarrhea
- □ Painful bowel movements
- □ Change in bowel habits
- □ Rectal bleeding or blood in stool

Musculoskeletal / Pain

□ Muscle aches or cramping □ Joint pain or stiffness □ Joint swelling □ Low Back Pain Neck Pain □ Difficulty Walking or Standing Osteoporosis - Bone Scan □ History of Injuries and Accidents Date: Date:

Neurological / Psychological

- □ Headaches
- □ Daily □ Weekly □ Rarely
- □ Migraines
- □ Sinus headaches
- □ Tension headaches
- □ Dizziness or Light headed
- □ Convulsions or seizures
- □ Tremors
- □ Paralysis
- □ Numbness or tingling
- □ Depression
- □ Anxiety / Nervousness
- □ Memory Loss / Confusion
- □ Abuse Survivor

Genitourinary □ Frequent urination □ Nighttime urination □ Urgency / burning / painful urination □ Blood in urine \Box Change in urine stream □ Incontinence or dribbling □ Kidney stones □ Sexual difficulty **Testicle Pain** \Box <u>Male</u>: Last PSA □ <u>Male</u>: Prostate Check Female: Last Menstrual Period Menses LMP □ Regular □ Irregular □ Menopausal □ Irritability Emotional Other Vaginal discharge or itching # Pregnancies # Live Births_ Menopause Symptoms: □ Hot flashes □ Night sweats □ Dryness □ Other_ Date last Mammogram_ □ Normal □ Abnormal Date last Pap Smear □ Normal □ Abnormal Integumentary (Skin / Breast) /

Immune System

- \Box Rash, itching, hives
- □ Dry skin
- □ Eczema or Psoriasis
- □ Change in skin, hair or nails
- \Box New or changing moles
- □ Breast pain or discharge
- □ Breast lump
- □ Food □ Seasonal \Box Allergies: Environmental
- □ Immune Deficiency/Compromise

- Length of Menses # of days Monthly Cycle # of days PMS □ Fatique
 - □ Breast Tenderness/Swelling

Date _

Welcome to Alpenglow Acupuncture, LLC

Patient Name:DOB:Intake Date: Reason for Visit:								
Patient Medical History Please check if you have ever had any of the following. Leave blank if uncertain. Measles Intermorrhoids Arthritis IDDS or HV Mumps IS / Diverticulitis Osteoprosis Infectious Mono / Epstein Barr Virus Dibitheria Uicer IBadder Infectious STD Snallpox Giaucoma Kidney Disease Infectious Mono / Epstein Barr Virus Snallpox Giaucoma Kidney Disease Infectious Mono / Epstein Barr Virus Monoping Cough Cancer Back Trouble Invision Neumatic Fever Diabetes Hernia Beeding Tendency Munoping Cough Cancer Back Trouble Brusing Pherunonia Heart Disease Other Diseases Other Diseases Asthra High / Low Biood Pressure Chronic Fatigue Date of Last Physical Exam Mercidus Mitral Valve Prolapse Fibromyalgia Date Mercidus Never Previous Hogenatic Events Date Mercidus Rerely Never Rere leadenches Evercise: Steep Habits: Exposure to Mercidus Rerely Never <td colspan="4">Patient Name:</td> <td></td> <td>DOB:</td> <td>Intake Date:</td> <td></td>	Patient Name:					DOB:	Intake Date:	
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Who do you see for Medical Doctors?_____

Children