Alpenglow Acupuncture LLC

Patient Name _____ Date _____

Constitutional Symptoms
☐ General health the past year
☐ Good ☐ Poor
☐ Recent weight change
_____
☐ Fever
☐ Fatigue / Poor Energy
☐ Sleep problems / snoring

Eyes
☐ 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
☐ Pain in legs with walking
☐ Shortness of breath at rest
☐ Swelling of feet or ankles
☐ Varicose veins
☐ Cold Extremities

Respiratory
☐ Cough
☐ 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:
#/day_____☐ Easy ☐ Hard
☐ 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
☐ Change in urine stream
☐ Incontinence or dribbling
☐ Kidney stones
☐ Sexual difficulty
☐ Male: Testicle Pain
☐ Male: Last PSA_____
Prostate Check_____

Female:
Last Menstrual Period_____
Menses LMP _____
☐ Regular ☐ Irregular
☐ Menopausal
Length of Menses_____ # of days
Monthly Cycle_____# of days
PMS ☐ Irritability ☐ Fatigue
☐ Emotional
☐ Breast Tenderness/Swelling
☐ 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
☐ Rash, itching, hives
☐ Dry skin
☐ Eczema or Psoriasis
☐ Change in skin, hair or nails
☐ New or changing moles
☐ Breast pain or discharge
☐ Breast lump
☐ Allergies: ☐ Food ☐ Seasonal
☐ Environmental
☐ Immune Deficiency/Compromise

Welcome to Alpenglow Acupuncture, LLC

As a new patient, and to help us understand any health issues you may have, please fill out the information below to the best of your ability. All information is confidential

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	☐ Hemorrhoids	☐ Arthritis	☐ AIDS or HIV
☐ Mumps	☐ IBS / Diverticulitis	☐ Osteoporosis	☐ Infectious Mono / Epstein Barr Virus
☐ Chicken Pox	☐ Crohn's Disease	☐ Hives or Eczema	☐ Hepatitis A B C
☐ Diphtheria	☐ Ulcer	☐ Bladder Infections	☐ STD
☐ Smallpox	☐ Glaucoma	☐ Kidney Disease	☐ Blood/Plasma Transfusion
☐ Polio	☐ Epilepsy	☐ Thyroid Disease	☐ Anemia
☐ Rheumatic Fever	☐ Diabetes	☐ Hernia	☐ Bleeding Tendency
☐ Whooping Cough	☐ Cancer	☐ Back Trouble	☐ Bruising
☐ Tuberculosis	☐ Stroke	☐ Migraine Headaches	☐ Other Diseases (Please list)
☐ Pneumonia	☐ Heart Disease	☐ Head Injury	_____
☐ Bronchitis	☐ Mitral Valve Prolapse	☐ Fibromyalgia	_____
☐ Asthma	☐ High / Low Blood Pressure	☐ Chronic Fatigue	
☐ Respiratory Disease			Date of Last Physical Exam

Previous Hospitalizations / Surgeries / Serious Illnesses / Traumatic Events

Date

_____ _____
_____ _____
_____ _____
_____ _____

Medications

(include herbs, supplements and over the counter items)

_____
_____
_____
_____

Allergies:_____

Patient Social History

Marital Status:	Alcohol use:	Caffeine use:	Smoking:	Exercise:	Sleep Habits:	Exposure to:
☐ Single ☐ Married ☐ Living w/partner ☐ Separated ☐ Divorced ☐ Widow	☐ Never ☐ Rarely ☐ Moderate ☐ Daily Amount/day:	☐ Never ☐ Rarely ☐ Moderate ☐ Daily Amount/day:	☐ Never ☐ Previously, but quit:_____ ☐ Currently smoking ___ packs/day	☐ Rare ☐ Occasional ☐ Regularly ☐ Daily Type of exercise:	☐ 6-8 hours ☐ Insomnia ☐ Wake up too early ☐ Difficulty falling asleep ☐ Dreamer	☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Noise ☐ Vaccinations

Drug use: ☐ Never ☐ Type/frequency _____

Special Diet: ☐ Yes if so, type:_____

Family Medical History

	Age	Diseases	Date deceased, cause of death
Spouse	___	_____	_____
Father	___	_____	_____
Mother	___	_____	_____
Siblings	___	_____	_____
	___	_____	_____
Children	___	_____	_____
	___	_____	_____

Who do you see for Medical Doctors?_____