Harmony and Health Acupuncture

4020 N 20th St #212 Phoenix, AZ 85016 602-955-5444

Confidential Patient Information Form

PERSONAL INFORMATION

First Name____________________Last Name____________________Date____________

Address____________________City__________State________Zip______

Home Phone______________Work Phone______________Cell Phone______________

Best Phone to Reach You____________________

Email Address____________________Please check if you are willing for us to contact you by email ☐Yes ☐ No

Date of Birth______Marital Status______Number of Children___ Age(s) of Children______________

Occupation ____________________Employer______________________________

Highest level of education completed: ☐High School ☐Bachelors ☐Masters ☐Doctorate ☐Professional ☐Other__________

In emergency notify:______________Emergency Phone Number:______________________

Primary Care Physician:________________Last Seen:__________________________

Do you have out of network benefits that cover acupuncture? ☐Yes ☐No Name of your Insurance Company:__________

Have you had acupuncture before? ☐No ☐Yes Name of Acupuncturist:______________________

Major Complaint(s) in order of significance to you:

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Are you being treated for this condition by anyone else? ☐No ☐Yes If yes, who____________________

Has this condition been diagnosed by a Medical Doctor? ☐ No ☐ Yes (Diagnosis) ____________________

Do you have any known or suspected allergies ☐No ☐Yes (List) ____________________

Height _____ Weight _____Age ______ Gender: ☐Male ☐Female

Please List the Medications and Supplements you are currently taking:

Drug/Supplement	Reason for Taking	For how Long	Dose	Frequency

Are you currently taking Coumadin/warfarin or heparin? ☐ No☐ Yes

MEDICAL INFORMATION

Please list any serious diseases, injuries, surgeries or hospitalizations you have had and the year they occurred:

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Please check any that apply to your medical history:

□ADD/ADHD	□Eating Disorder	□Lyme's Disease	□Seizures/Epilepsy
□Alcoholism	□Fibromyalgia	□Mental Illness	□Sinus Infections
□Allergies	□Glaucoma	□Migraines	□Skin Disease
□Arthritis	□Heart Disease	□Multiple Sclerosis	□Stroke
□Bipolar Disease	□Hepatitis/Liver disease	□Osteoporosis	□Substance Abuse
□Birth Trauma	□High Blood Pressure	□Pacemaker	□Thyroid Disease
□Bleeding Disorder	□HIV/AIDS	□Polio	□Tuberculosis
□Blood Disease	□Immune Disorder	□Prostate Problems	□Ulcer
□Cancer or Tumor	□Joint Replacement	□PTSD	□Vein Condition
□Depression	□Kidney Disorder	□Rheumatic Fever	□Venereal Disease/STD
□Diabetes	□Low Blood Pressure	□Scoliosis	□Other
□Emphysema	□Lupus	□Scarlet Fever	

LIFESTYLE INFORMATION

Please include daily amount used within the past 2 months:

Tobacco: □No □Yes Amount:________ Alcohol: □No □Yes Amount: _______ Coffee □No □Yes Amount:______________

Recreational Drugs: □No □Yes Amount:________ Daily water intake:________ Daily soda intake: __________

Are you a vegetarian or vegan? □No □Yes Hours of sleep/night:__________________

How would you rate the following areas of your health in the past month?

Energy: □Great □Good □Fair □Poor Comments:____________________________________

Digestion: □Great □Good □Fair □Poor Comments:____________________________________

Urination: □Great □Good □Fair □Poor Comments:____________________________________

Bowel movements □Great □Good □Fair □Poor Comments:____________________________________

Sleep: □Great □Good □Fair □Poor Comments:____________________________________

Appetite: □Great □Good □Fair □Poor Comments:____________________________________

Physical exercise you do regularly:________________________________ Hours you spend at work per week: ______________

How do you feel about the following areas of your life in the past month?

Significant Other: □Great □Good □Fair □Poor □N/A Comments:________________________________

Family: □Great □Good □Fair □Poor □N/A Comments:________________________________

Diet: □Great □Good □Fair □Poor □N/A Comments:________________________________

Sex Life: □Great □Good □Fair □Poor □N/A Comments:________________________________

Self: □Great □Good □Fair □Poor □N/A Comments:________________________________

Work: □Great □Good □Fair □Poor □N/A Comments:________________________________

Exercise: □Great □Good □Fair □Poor □N/A Comments:________________________________

How would your rate your current stress level? □Extreme □Very High □High □Moderate □Low

HEALTH INVENTORY

Please check all that currently pertain to you

Overall Temperature
☐ Cold Hands
☐ Cold feet
☐ Sweaty hands
☐ Sweaty feet
☐ Body feels hot often
☐ Body feels cold often
☐ Afternoon flushes
☐ Night Sweats
☐ Heat in the hands, feet and chest
☐ Hot flashes any time of day
☐ Thirsty a lot
☐ Perspire easily
☐ Lack of perspiration

Overall Energy (Lu, Ki)
☐ Shortness of breath
☐ Difficulty keeping eyes open during day
☐ General weakness
☐ Easily catch colds
☐ Low energy
☐ Feel worse after exercise

Overall function of the blood (Lu, Ki Ht)
☐ Dizziness
☐ Floating spots in eyes
☐ Poor memory

Heart Function
☐ Palpitations
☐ Anxiety
☐ Sores on tip of tongue
☐ Restlessness
☐ Mental confusion
☐ Chest pain
☐ Frequent or vivid dreams
☐ Easily startled
☐ Wake un-refreshed

Stomach Function
☐ Burning sensation after eating
☐ Large appetite
☐ Bad breath
☐ Mouth (canker sores)
☐ Bleeding swollen or painful gums
☐ Heartburn
☐ Acid regurgitation
☐ Ulcer
☐ Belching
☐ Hiccoughs
☐ Stomach pain
☐ Vomiting

Eyes
☐ Itchy
☐ Bloodshot
☐ Dry
☐ Watery
☐ Gritty
☐ Blurry vision
☐ Decreased night vision

Lung Function
☐ Nasal discharge Color:____________
☐ Post nasal drip
☐ Sneezing
☐ Cough
☐ Nose bleeds
☐ Sinus congestion
☐ Dry mouth
☐ Dry throat
☐ Dry nose
☐ Dry skin
☐ Skin rashes, hives
☐ Allergies To:____________________
☐ Alternating chills and fever
☐ Overall achy feeling
☐ Stiff neck (recent)
☐ Stiff shoulders (recent)
☐ Sore Throat
☐ Difficulty breathing
☐ Sadness, Grief
☐ Melancholy

Spleen (Digestive) Function
☐ Low appetite
☐ Abrupt weight gain
☐ Abrupt weight loss
☐ Abdominal bloating
☐ Abdominal gas
☐ Gurgling noise in stomach
☐ Fatigue after eating
☐ Prolapsed organs, bladder, rectum, uterus
☐ Easy bruising
☐ Hemorrhoids
☐ Pensive
☐ Over-thinking
☐ Worry

Intestine Function Sp, St, LI, SI
☐ Loose stool
☐ Constipated
☐ Frequent stool
☐ Incomplete feeling
☐ Diarrhea
☐ Blood in stool
☐ Mucus in stool
☐ Undigested food in stool

Dampness trapped in body
☐ General sensation of heaviness in the body
☐ Mental heaviness
☐ Mental sluggishness
☐ Mental fogginess
☐ Swollen hands
☐ Swollen feet
☐ Swollen joints
☐ Chest congestion
☐ Nausea
☐ Snoring

Libido (Sex Drive)
☐ Normal ☐ High ☐ Low

Liver/Gallbladder Function
☐ Alternating diarrhea & constipation
☐ Chest pain
☐ Tight sensation in chest
☐ Pain below ribcage
☐ Bitter taste in mouth
☐ Anger easily
☐ Frustration
☐ Depression
☐ Irritability
☐ Headache at temples or top of head
☐ Tingling sensation
☐ Numbness
☐ Tendonitis
☐ Muscle spasms
☐ Muscle twitching
☐ Muscle cramping
☐ Seizures
☐ Convulsions
☐ Feeling of lump in the throat
☐ Neck tension
☐ Neck limited range of motion
☐ Shoulder tension
☐ Shoulder limited range of motion
☐ Hip pain
☐ High pitched ringing in ears
☐ Gall stones
☐ Clenching of teeth at night
☐ Poor circulation
☐ Soft brittle nails

Kidney, Bladder Function
☐ Frequent cavities
☐ Easily broken bones
☐ Sore knees
☐ Weak knees
☐ Cold sensation in the knees
☐ Low back pain
☐ Memory problems
☐ Excessive hair loss
☐ Low pitched ringing in the ears
☐ Kidney stones
☐ Bladder infections
☐ Wake at night 2 times or more to pee
☐ Lack of bladder control
☐ Fear

Urination
☐ Normal color, clear
☐ Dark yellow
☐ Reddish
☐ Cloudy
☐ Scanty
☐ Profuse
☐ Strong odor
☐ Burning, painful
☐ Difficult
☐ Urgent
☐ Frequent

Women Only:

Are you pregnant right now ☐No ☐Yes ☐Maybe ☐Trying   Method of birth control:____

Date of last menses: ____________ Age at menopause:_____________ ☐Vaginal discharge ☐Bleeding or spotting between periods

Typical length of flow (days):____________Typical length of cycle (from 1st day of flow to day before next flow):________

Number of pregnancies:_________ Births: ________ Abortions:_____________ Miscarriages:__________

During your flow (circle all that apply): Normal red, bright red, pale, brown, dark, purple, normal quantity, heavy quantity, light quantity, clots, dull pain/cramps, sharp pain/cramps, nausea

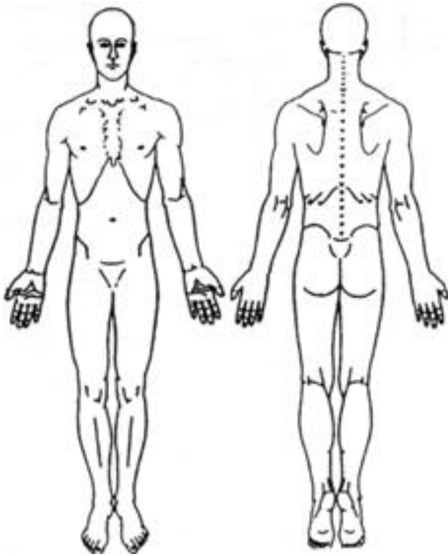
Do you experience any of the following pre-menstrual symptoms?

☐Nausea	☐Vomiting	☐Water retention	☐Breast swelling	☐Breast tenderness
☐Food cravings	☐Headaches	☐Migraines	☐Depression	☐Irritability
☐Anxiety	☐Other:______________________			

Men Only: **Mark all that apply**

☐Swollen testes	☐Premature ejaculation	☐Other_______________________
☐Testicular pain	☐Difficult urinary flow	
☐Impotence	☐Feeling of coldness or numbness in external genitalia	

PAIN



Please answer the following questions if you have pain.
Indicate on the diagram on the left the areas of pain.

Quality of Pain: ☐Dull ☐ Sharp ☐ Stabbing ☐ Sore ☐ Cramping ☐ Burning
☐ Constant ☐ Fixed ☐ Moves about

What helps the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture
☐ Massage ☐ Nothing ☐ Other ______________________

What aggravates the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure
☐ Moisture ☐ Massage ☐ Nothing ☐ Other ______________

How did you hear about Harmony and Health Acupuncture? ☐ Web Site ☐ A Presentation ☐ Insurance Company

☐ Referred by:________________________________   ☐ Other:_____________________________________

The above information 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 Harmony and Health Acupuncture and Herbal Medicine **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): ____