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_____

Cell Phone_____ Email Address_____

Date of Birth_____ Marital Status_____ Children ☐No ☐Yes Age(s) of Children_____

Occupation _____ Employer_____

In emergency notify:_____ Emergency Phone Number:_____

Primary Care Physician:_____ Last Seen:_____

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

1. _____
2. _____
3. _____
4. _____
5. _____
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 are you taking any blood thinners such as Eliquis, Coumadin/warfarin or heparin? ☐ No☐ Yes

MEDICAL HISTORY

List any serious diseases, diagnoses, significant medical conditions:

List any surgeries:

List any mental health conditions:

List any hospitalizations:

List any significant accidents/injuries:

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:_____

Do you have any food or dietary restrictions □No □Yes Please list:_____

Sleep: Please check all that currently apply:
□ 8-9 hours per night □7 hours per night □6 hours or less □Restless □Difficulty falling asleep (greater than 20 min)
□Waking in the night after falling asleep □Night sweats □Dream distrubed sleep □Wake up often to pee
□Wake up un-refreshed

How would you rate the following areas of your health in the past **2 months**?

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

Stress Level: □Extreme □High □Moderate □Low Comments:_____

How do you feel about the following areas of your life in the past **2 months?**

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:_____

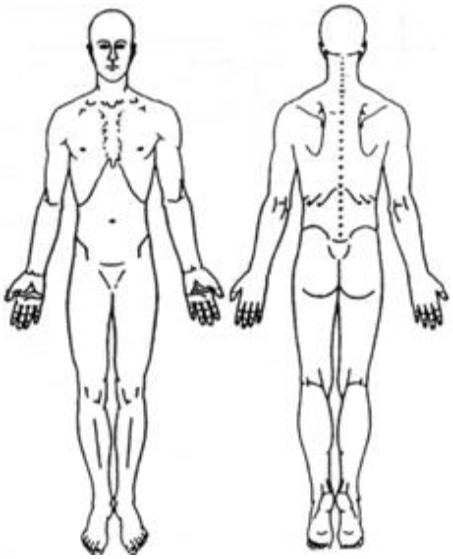
Self: □Great □Good □Fair □Poor □N/A Comments:_____

Work: □Great □Good □Fair □Poor □N/A How many hours of work per week:_____

Exercise: □Great □Good □Fair □Poor □N/A What Kind of exercise do you do regularly?:_____

HEALTH INVENTORY **Please check all that currently pertain to you in the <u>past 2 months</u>**

☐Cold Hands ☐Cold feet ☐Cold lower body ☐Body feels hot often ☐Body feels cold often ☐Afternoon heat flushes ☐Hot flashes any time of day ☐Thirsty a lot ☐Sweat a lot ☐Lack of sweat ☐Headache ☐Migraine ☐Clenching of teeth at night ☐Dizziness ☐Red eyes ☐Blurred vision ☐Visual floaters ☐Poor night vision ☐Dry eyes ☐Yellow eyes ☐Ringing in ears ☐Hearing loss ☐Nasal discharge/runny nose ☐Postnasal drip ☐Sneezing ☐Cough ☐Nose bleeds ☐Sinus congestion ☐Sore Throat ☐Dry mouth, throat ☐Dry nose ☐Dry skin ☐Skin rashes, hives ☐Allergies To:_____ ☐Feeling of coming down with something ☐Heart palpitations ☐Shortness of breath ☐Difficulty taking a breath ☐Chest conjestion ☐Tight sensation in chest ☐Chest pain ☐Pain below ribcage	☐Feeling of lump in the throat ☐Burning sensation after eating ☐Low appetite ☐Unconfortable/bloat after eating ☐Large appetite ☐Mouth sores ☐Bitter or icky taste in mouth ☐Bleeding swollen or painful gums ☐Heartburn ☐Acid regurgitation ☐Belching ☐Hiccoughs ☐Stomach pain ☐Nausea ☐Vomiting ☐Abrupt weight gain ☐Abrupt weight loss ☐Abdominal bloating ☐Abdominal gas ☐Gurgling noise in stomach ☐Fatigue after eating ☐Prolapsed bladder, rectum, uterus ☐Hemorrhoids ☐Loose stool ☐Frequent stool ☐Diarrhea ☐Constipated ☐Alternating diarrhea & constipation ☐Incomplete bowel movement ☐Blood in stool ☐Mucus in stool ☐Undigested food in stool ☐Lack of bladder control ☐Urination burning, painful ☐Urination difficult ☐Urination urgent ☐Urination frequent	☐Tingling sensation ☐Numbness ☐Tendonitis ☐Muscle spasms/twitching/cramping ☐Neck tension/pain ☐Neck limited range of motion ☐Jaw pain ☐Shoulder tension/pain ☐Shoulder limited range of motion ☐Elbow pain ☐Hip pain ☐Sore knees ☐Weak knees ☐Back pain ☐Ankle pain ☐Swollen or painful hands ☐Swollen or painful feet ☐Swollen joints ☐Spider veins ☐Pain other: _____ ☐Anxiety ☐Depression ☐Restlessness ☐Mental confusion ☐Pensive ☐Over-thinking ☐Worry ☐Sadness, Grief ☐Melancholy ☐Anger easily ☐Frustration ☐Depression ☐Irritability ☐Fear ☐Mental sluggishness/heaviness/foggy ☐Weak fingernails ☐General weakness ☐Easily catch colds ☐Sensation of heaviness in the body ☐Feel worse after exercise ☐Poor memory or concentration ☐Excessive hair loss



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 _____

WOMEN ONLY:
Are you pregnant right now □No □Yes □Maybe □Trying Birth control currently_____
Birth control past (indicate age):_____

Number of pregnancies:_____ Births: _____ Abortions:_____ Miscarriages:_____

Date of last period (1st day of bleeding): _____ Post menopause □No □Yes
Number days in cycle (number of days from the first day of bleeding to the next period)_____

Please describe your menstrual flow, check all that apply:
□1-2 days of bleeding □3-5 days of bleeding □6-7 days of bleeding □7+ days of bleeding
□Light flow □Moderate flow □Heavy flow □Spotting before or after
□Period starts and stops □Small clots □Large clots

Please describe any pain you might have related to your cycle:
□Mid cycle □Starts before flow □Starts at beginning of flow □Mild (1-4/10)
□Moderate (5-7/10) □Severe (8+/10) □I take pain medication □Pain lasts 1 day □Pain lasts 2 or more days

Do you experience any of the following?
□Pain with intercourse □Low libido □Frequent UTI's □Abnormal vaginal discharge
□Headaches with your period □Irritability/PMS □Acne □Anxiety with your period
□Excessive facial hair □Vaginal discharge □Breast swelling or tenderness □Depression with your period

PLEASE COMPLETE THIS SECTION ONLY IF YOU ARE TRYING TO CONCEIVE:
How long have you been trying to conceive?_____

Have you and your partner completed any of the following tests?
□ Cycle day 3 blood work (FSH, LH, Estradiol) □ Pelvic ultrasound □Hysterosalpingogram (HSG) □ Semen analysis

Are you currently undergoing any fertility treatments? Please include name of facility and physician: _____
_____

What is your ideal family size (if you could have anything you wanted)? _____

Do you have or suspect any of the following: □ Endometriosis □ PCOS □ Anovulation □ Male factor fertility □ Short luteal phase □ Issues with egg or sperm quality □ Absent or irregular cycles □ Difficulty with intercourse (pain, logistics, timing etc) □ Immunological fertility issue □ Other _____ Do you have clear signs of ovulation □yes □no □uncertain

Is there anything else you would like me to know?_____

If you are trying to conceive with a male partner, please complete this section in full.

Does your male partner regularly engage in any of the following? □Alcohol □ Cigarettes/vape □Chewing tobacco

□Nicotine patches □ Cannabis □Hot tubs □ Hot baths □ Saunas □ Frequent use of laptop on lap □ Carrying cell phone in front pocket □ Occupational exposure to chemicals

How often is your partner able to maintain an erection sufficent for penetration? □Always □ Mostly □Not often □Very difficult

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): _____