One Space Community Acupuncture

PATIENT INFORMATION	PATIENT CONTACT INFORMATION
DATE	PHONE
NAME	EMAIL
AGE DOB	ADDRESS
OCCUPATION	CITY/STATE/ZIP

PRIMARY CARE INFORMATION	EMERGENCY CONTACT INFORMATION
PHYSICIAN	NAME
PHONE	RELATIONSHIP
DATE OF LAST CHECKUP	PHONE

HOW DID YOU HEAR ABOUT US?

HEALTH HISTORY

WHAT ARE YOU SEEKING TREATMENT FOR?
LIST YOUR TOP 3 COMPLIANTS IN ORDER OF IMPORTANCE:

1
2
3
HOW IS YOUR SLEEP?
HOW IS YOUR DIGESTION?
OVERALL ENERGY LEVEL?
OVERALL STRESS LEVEL?
LIST ANY ALLERGIES:
LIST MEDICATIONS OR SUPPLEMENTS:

SYMPTOMS YOU HAVE:

CURRENTLY	IN THE PAST YEAR	
☐	☐	DEPRESSION
☐	☐	ANXIETY
☐	☐	EXCESSIVE WORRY
☐	☐	EXCESSIVE ANGER
☐	☐	EXCESSIVE FEAR
☐	☐	MOOD SWINGS
☐	☐	DIFFICULTY FOCUSING
☐	☐	FATIGUE
☐	☐	HEADACHES / MIGRAINES
☐	☐	POOR SLEEP / INSOMNIA
☐	☐	VIVID DREAMING / NIGHTMARES
☐	☐	PALPITATIONS
☐	☐	POOR MEMORY
☐	☐	DIZZINESS

CHECK IF YOU HAVE EVER HAD:

- ☐ EPILEPSY/SEIZURES
- ☐ HEART ATTACK OR HAVE A PACEMAKER
- ☐ HEPATITIS A/B/C
- ☐ HIV/AIDS
- ☐ BLEEDING DISORDER OR HEMORRHAGE
- ☐ FAINTING
- ☐ DIABETES
- ☐ CANCER

LIST WITH DATES ANY HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES:

HEALTH HISTORY (CONTINUED)

PLEASE CHECK THE SYMPTOMS YOU HAVE:

CURRENTLY	IN THE PAST YEAR		CURRENTLY	IN THE PAST YEAR	
		PAIN, WEAKNESS OR NUMBNESS IN:			**GENITOURINARY:**
☐	☐	ARMS / HANDS	☐	☐	FREQUENT URINATION
☐	☐	LEGS / KNEES / FEET	☐	☐	POOR BLADDER CONTROL
☐	☐	BACK	☐	☐	BURNING WHEN URINATING
☐	☐	NECK / SHOULDERS	☐	☐	BLOOD IN URINE
☐	☐	WHOLE BODY ACHES	☐	☐	DARK / CLOUDY URINE
☐	☐	TREMORS OR SHAKING	☐	☐	SCANTY URINE OR DRIBBLING
☐	☐	STIFF / SWOLLEN JOINTS	☐	☐	FREQUENT UTI'S
		CARDIOVASCULAR:	☐	☐	KIDNEY STONES
☐	☐	HIGH / LOW BLOOD PRESSURE	☐	☐	LOW LIBIDO
☐	☐	HIGH CHOLESTEROL			**GASTROINTESTIONAL:**
☐	☐	IRREGULAR / RAPID HEARTBEAT	☐	☐	POOR APPETITE
☐	☐	BLOOD CLOTS	☐	☐	EXCESSIVE HUNGER / THIRST
☐	☐	SWELLING OF ANKLES	☐	☐	NAUSEA / VOMITING
☐	☐	VARICOSE VEINS	☐	☐	BELCHING, GAS, BLOATING
☐	☐	CHEST PAIN	☐	☐	ABDOMINAL PAIN
		EYES/EARS/NOSE/THROAT:	☐	☐	INDIGESTION
☐	☐	RINGING IN EARS	☐	☐	ACID REFLUX / HEARTBURN
☐	☐	HEARING LOSS	☐	☐	STOMACH ULCER
☐	☐	EARACHE	☐	☐	JAUNDICE
☐	☐	JAW PAIN / TMJ	☐	☐	GALL BLADDER TROUBLE
☐	☐	EYE PAIN / STRAIN	☐	☐	BLOOD IN STOOL
☐	☐	NOSE BLEEDS	☐	☐	HEMORRHOIDS
☐	☐	LOSS OF SENSE OF SMELL	☐	☐	CONSTIPATION
☐	☐	SORES IN MOUTH / TONGUE	☐	☐	DIARRHEA
☐	☐	PERSISTENT COUGH	☐	☐	WEIGHT LOSS / GAIN
☐	☐	PRODUCTION OF PHLEGM			**FOR MEN:**
☐	☐	WHEEZING	☐	☐	ERECTILE DYSFUNCTION
☐	☐	SHORTNESS OF BREATH	☐	☐	PROSTRATE PROBLEMS
☐	☐	COUGHING UP BLOOD			**FOR WOMEN:**
☐	☐	FREQUENT COLDS	☐	☐	MENOPAUSAL SYMPTOMS
☐	☐	SINUS INFECTIONS	☐	☐	HYSTERECTOMY
☐	☐	ALLERGIES	☐	☐	VAGINAL / YEAST INFECTION
☐	☐	ASTHMA	☐	☐	PAINFUL PERIODS
		SKIN:	☐	☐	IRREGULAR PERIODS
☐	☐	RASH / ITCHING / HIVES	☐	☐	PREMENSTRUAL SYNDROME (PMS)
☐	☐	DRY SKIN	☐	☐	PROLAPSE
☐	☐	ACNE / BOILS / INFECTIONS	☐	☐	OVARIAN CYSTS / UTERINE FIBROIDS
☐	☐	HAIR FALLING OUT	# OF PREGNANCIES		
☐	☐	WEAK / BRITTLE NAILS	# OF LIVE BIRTHS		
☐	☐	SORES THAT WON'T HEAL	# OF MISCARRIAGES		
☐	☐	SPONTANEOUS SWEATING	COULD YOU BE PREGNANT?		

COMPLETED BY:	DATE: