HARTER ACUPUNCTURE CENTER

8010 E Morgan Trail, Suite 1, Scottsdale, AZ 85258 | 480-313-8423

CONFIDENTIAL PATIENT FORM

PATIENT INFORMATION

First Name_____ Last Name_____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Are willing for us to contact you by email ☐ Yes ☐ No

Date of Birth _____ Marital Status _____ Number of children _____ Age(s) of children _____

Height _____ Weight _____ Age _____ Gender: ☐ Male ☐ Female

Occupation _____ Employer_____

Highest level of education completed ☐ HS ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Professional ☐ Other _____

In emergency notify _____ Emergency Phone Number _____

Primary Care Physician _____ Date Last Visit _____

MEDICAL INFORMATION

Major Complaint(s) in order to significance to you

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

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

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

Do you have any known or suspected allergies?

☐ Yes ☐ No (List) _____

Please list the medications and supplements you are currently taking:

Drug/supplement	Reason for taking	How long	Dose	Frequency

MEDICAL INFORMATION

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

_____

_____

_____

Please check any that apply to your medical history:

- □ ADD/ADHD
- □ Alcoholism
- □ Allergies
- □ Arthritis
- □ Bipolar disorder
- □ Bleeding disorder
- □ Blood Disease
- □ Cancer or tumor
- □ Depression
- □ Diabetes
- □ Emphysema
- □ Eating disorder
- □ Fibromyalgia
- □ Glaucoma
- □ Heart disease
- □ Hepatitis/liver disease
- □ High blood pressure
- □ HIV/AIDS
- □ Immune disorder
- □ Joint replacement
- □ Kidney disorder
- □ Low blood pressure
- □ Lupus
- □ Lyme disease
- □ Mental illness
- □ Migraines
- □ Multiple sclerosis
- □ Osteoporosis
- □ Pacemaker
- □ Polio
- □ Prostate problems
- □ PTSD
- □ Rheumatic fever
- □ Scoliosis
- □ Scarlet fever
- □ Seizures/epilepsy
- □ Sinus infections
- □ Skin disease
- □ Stroke
- □ Substance abuse
- □ Thyroid disease
- □ Tuberculosis
- □ Ulcer
- □ Vein condition
- □ Venereal Disease/STD
- □ Other_____

LIFESTYLE INFORMATION

Please include daily amount used within the past 2 months:

Tobacco: ☐ Yes ☐ No Amount _____

Coffee: ☐ Yes ☐ No Amount _____

Alcohol: ☐ Yes ☐ No Amount _____

Recreational Drugs: ☐ Yes ☐ No Amount _____

Daily water intake: Amount _____

Daily soda intake: Amount _____

Are you a vegetarian or vegan? ☐ Yes ☐ No

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 Movement:	□ Great	□ Good	□ Fair	□ Poor	Comments:_____
Sleep:	□ Great	□ Good	□ Fair	□ Poor	Comments:_____
Appetite:	□ Great	□ Good	□ Fair	□ Poor	Comments:_____

How much physical exercise you do regularly? _____ Hours of work per week: _____

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

Significant Other:	□ Great	□ Good	□ Fair	□ Poor	□ NA	Comments:_____
Family:	□ Great	□ Good	□ Fair	□ Poor	□ NA	Comments:_____
Diet:	□ Great	□ Good	□ Fair	□ Poor	□ NA	Comments:_____
Sex Life:	□ Great	□ Good	□ Fair	□ Poor	□ NA	Comments:_____
Self:	□ Great	□ Good	□ Fair	□ Poor	□ NA	Comments:_____
Work:	□ Great	□ Good	□ Fair	□ Poor	□ NA	Comments:_____
Exercise:	□ Great	□ Good	□ Fair	□ Poor	□ NA	Comments:_____

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

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
□ Thirsty a lot
□ Perspire easily
□ Lack of perspiration

Overall Energy
□ 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
□ 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
□ 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? ☐ Yes ☐ No ☐ Maybe ☐ Trying Method of birth control? _____

Date of last menses? _____ Age at menopause? _____

Vaginal discharge? ☐ Yes ☐ No Bleeding or spotting between periods? ☐ Yes ☐ No

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

Number of pregnancies: _____ Birth: _____ Abortions: _____ Miscarriages: _____

During your flow (check all the apply):

☐ Normal red	☐ Dark	☐ Light quantity	☐ Nausea
☐ Bright red	☐ Purple	☐ Clots	
☐ Pale	☐ Normal quantity	☐ Dull pain/cramps	
☐ Brown	☐ Heavy quantity	☐ Sharp pain/cramps	

Men Only: (check all that apply)

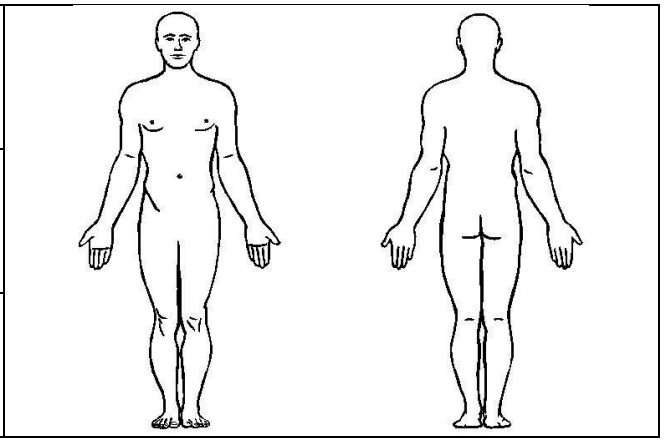
☐ Swollen testes	☐ Premature ejaculation	☐ Impotence
☐ Testicular pain	☐ Difficult urinary flow	☐ Other _____

PAIN INFORMATION

Please check the following questions if you have pain.

Pain Quality?	☐ Dull	☐ Sore	☐ Constant
	☐ Sharp	☐ Cramping	☐ Fixed
	☐ Stabbing	☐ Burning	☐ Moves About
What helps?	☐ Ice	☐ Movement	☐ Massage
	☐ Heat	☐ Pressure	☐ Nothing
	☐ Rest	☐ Moisture	☐ Other
What aggravates?	☐ Ice	☐Movement	☐ Massage
	☐ Heat	☐ Pressure	☐ Nothing
	☐ Rest	☐ Moisture	☐ Other

Indicate on the diagram on the left the areas of pain.



How did you hear about Harter Acupuncture Center?

☐ Website ☐ Presentation ☐ Insurance ☐ 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 Harter Acupuncture Center **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: _____ Date _____