Blue Sage Acupuncture & Herbs

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GENERAL PATIENT INFORMATION Date: ____/____/_____

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell/Work Phone: _____

Email address: _____

To retain your health care privacy, may we contact you at these phone numbers? Yes No
If No, what is the best way to reach you to retain your privacy? _____

Would you like to receive our monthly email newsletter
(your email address will not be used for any other purpose)? Yes No

Age: _____ Date of Birth: _____/_____/_____ Place of Birth: _____

Guardian (if under 18 years of age): _____

Person responsible for your account: _____

Gender: Female / Male / Relationship Status: _____

Occupation: _____ Employer: _____

How did you hear about us? _____

Family Physician: _____ Phone: _____

Date of last checkup? _____

Emergency Contact Name, Phone Number and Relation to Patient:_____

_____

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No

Primary reason for this visit:

1.

2.

3.

Current medications: (attach your own if necessary) Include prescriptions AND over-the-counter medications.

Medication	Dosage	Reason	How Long?	Prescribed By

Supplements: _____
_____
_____

Diet

Please indicate your use and frequency of the following:

	How much?	How often?		How much?	How often?
Water	_____	_____	Alcohol	_____	_____
Soda	_____	_____	Tobacco	_____	_____
Coffee/Caffeinated Tea	_____	_____	Recreational drugs	_____	_____

Meals

What do you eat? Please list your typical meals:

Breakfast _____

Lunch _____

Dinner _____

Snacks / Desserts _____

Cravings _____

Anything you do not eat? _____

Allergies

Please list any allergies (food, drug, seasonal, environmental) _____

_____

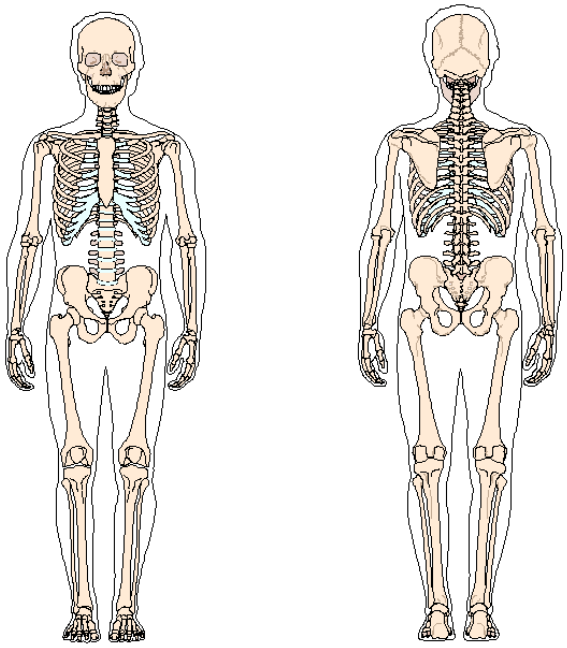
Significant Illness

Please indicate any significant illnesses you have had:

___High/low blood pressure (circle all applicable)	___IBS
___Cancer	___Gastritis/Pancreatitis (circle all applicable)
___Ulcers	___Liver/Gallbladder Disease
___Chronic Fatigue	___HIV / AIDS (circle all applicable)
___Asthma	___Infertility
___Diabetes	___Thyroid Disease
___Seizures	___Kidney Disease
___Anemia	___Alcoholism
___Hepatitis A / B / C (circle all applicable)	___Heart Disease
___Herpes Simplex Type 1/ Type 2 (circle all applic.)	

Musculoskeletal:

Circle areas of pain and inflammation in your body:



What makes the pain better?
_____

What makes it worse?
_____

Have you ever been hospitalized? Y N
If yes, for what? _____
_____
_____
_____
_____

Have you ever had surgery? Y N If yes, for what?
_____
_____
_____
_____
_____
_____

Sleep:

Number of hours a night _____	Frequent waking? _____
Time to bed _____	Feel rested on waking?_____
Time to wake _____	Vivid dreams? _____
Trouble falling asleep? _____	Worrying / Racing mind? _____
Trouble staying asleep? _____	Heart palpitations? _____

Energy Level: on a scale of 1 to 10 (10 being the most energetic): _____

Exercise: What type(s)?_____ How often? _____

Outlook:

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

	5 = Great	4 = Good	3 = Fair	2 = Poor	1 = Bad
Self	5	4	3	2	1
Significant Other	5	4	3	2	1
Family	5	4	3	2	1
Spirituality	5	4	3	2	1
Diet / Exercise	5	4	3	2	1
Sex	5	4	3	2	1
Work	5	4	3	2	1

Anything you'd like to share about the above areas of your life? _____
_____
_____

Do you have a history of:

☐ Depression ☐ Anxiety ☐ PTSD (Post Traumatic Stress Disorder)
☐ Manic Depression ☐ Panic Attacks ☐ Other _____

Symptoms

Please check (circle specifics) if any of these symptoms have been a significant concern for you in the past year:

General

- ☐ Chills / Excess heat
- ☐ Bleed / bruise easy
- ☐ Muscle weakness/fatigue
- ☐ Poor sleep
- ☐ Night sweats
- ☐ Palpitations
- ☐ Fatigue
- ☐ Sweat easily
- ☐ Poor balance
- ☐ Poor memory
- ☐ Tremor
- ☐ Anxiety / Stress
- ☐ Cold hands / feet
- ☐ Edema
- ☐ Trouble with weather changes

Gastrointestinal

- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Cravings
- ☐ Weight Loss/ Gain
- ☐ Strong thirst
- ☐ Nausea/Vomiting
- ☐ Gas/Belching
- ☐ Gallstones
- ☐ Trouble with fatty foods
- ☐ Indigestion
- ☐ Heartburn / Reflux
- ☐ Bloating
- ☐ Bad breath
- ☐ Constipation
- ☐ Loose Stool / Diarrhea
- ☐ Black/Pale stools
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Abdominal pain/cramps

Head / Ears / Eyes / Nose

- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Tinnitus
- ☐ Hearing loss
- ☐ Earaches/infections
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor vision/Eye Strain
- ☐ Near/ Far sighted
- ☐ Poor night vision
- ☐ Floaters
- ☐ Sinus problems
- ☐ Allergies / Hayfever
- ☐ Runny nose / post-nasal drip
- ☐ Nose Bleed
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Dental/gum problems
- ☐ Cold Sores

Respiratory

- ☐ Difficulty swallowing
- ☐ Persistent sore throat
- ☐ Swollen glands
- ☐ Cough/wheeze
- ☐ Frequent colds
- ☐ Pneumonia
- ☐ Coughing blood
- ☐ Asthma
- ☐ Tightness in chest
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Bronchitis

Skin/Hair

- ☐ Rashes/Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Acne
- ☐ Changes in skin
- ☐ Skin growths (moles, tags)
- ☐ Brittle nails

Urinary

- ☐ Painful urination
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Urination at night
- ☐ Kidney stones
- ☐ Urinary tract infection
- ☐ Scanty urination
- ☐ Urgency
- ☐ Excessive urination
- ☐ Burning urination
- ☐ Bloody urine

Other

Any other health concerns or conditions you'd like us to know about?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

For Women Only:

Are you currently pregnant? _____	# of pregnancies _____
Planning to become pregnant? _____	# of live births _____
Are you using birth control? _____	# of miscarriages _____
What type?_____	# of abortions _____

How old were you when you had your first period? _____ When was the first day of your last period? _____
Average # of days in cycle _____ Average number of days of flow: _____
Average number of pads/tampons used per day: Day 1:____ Day 2: ____ Day 3: ____ Day 4: ____ Day 5: ____
Flow is: Light Normal Heavy
Color is: Pale Dark Bright Red Brown Purple
Blood clots? Yes No Size of clots_____

Do you experience any of the following before or during your menstrual period?

☐ Water retention	☐ Pain / cramping	☐ Nausea
☐ Breast tenderness / swelling	☐ Migraines	☐ Hot flashes
☐ Depression	☐ Insomnia	☐ Night sweats
☐ Irritability	☐ Diarrhea / Constipation	☐ Acne

Vaginal Discharge? Yes No If yes, is there a color or odor?_____
Is your libido: Low Normal High

Have you ever been diagnosed with any of the following:

☐ Endometriosis	☐ Cervical Dysplasia	☐ Ovarian Cysts
☐ Polycystic Ovary Syndrome	☐ Uterine Fibroids	☐ Fertility Issues
☐ Pelvic Inflammatory disease (PID)		

Age of menopause onset? _____ Menopause Symptoms: _____
Hormone Replacement therapy? Yes No
Date of last PAP smear _____ Results: _____
Other gynecological issues_____

For Men Only:
Date of last prostate check up: _____ Results: _____

Have you ever experienced any of the following:

☐ Groin pain	☐ Nocturnal emissions	☐ Prostate problems
☐ Decreased libido	☐ Swelling in testicles	☐ Dribbling urination
☐ Overactive libido	☐ Premature ejaculation	☐ Painful urination
☐ Testicular pain	☐ Fertility Issues	☐ Difficult urination
	☐ Impotence	☐ Incontinence

Other Men's health issues? _____