

## Welcome to Alpenglow Acupuncture, LLC

As a new patient, and to help us understand any health issues you may have, please fill out the information below to the best of your ability. All information is confidential

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Intake Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

**Patient Medical History** Please check if you have ever had any of the following. Leave blank if uncertain.

<input type="checkbox"/> Measles	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Arthritis	<input type="checkbox"/> AIDS or HIV
<input type="checkbox"/> Mumps	<input type="checkbox"/> IBS / Diverticulitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Infectious Mono / Epstein Barr Virus
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Hives or Eczema	<input type="checkbox"/> Hepatitis A B C
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> STD
<input type="checkbox"/> Smallpox	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood/Plasma Transfusion
<input type="checkbox"/> Polio	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Bleeding Tendency
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back Trouble	<input type="checkbox"/> Bruising
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Other Diseases (Please list)
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Head Injury	_____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Fibromyalgia	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> High / Low Blood Pressure	<input type="checkbox"/> Chronic Fatigue	_____
<input type="checkbox"/> Respiratory Disease			Date of Last Physical Exam

**Previous Hospitalizations / Surgeries / Serious Illnesses / Traumatic Events**

Date


**Medications** (include herbs, supplements and over the counter items)


Allergies: \_\_\_\_\_

**Patient Social History**

Marital Status:	Alcohol use:	Caffeine use:	Smoking:	Exercise:	Sleep Habits:	Exposure to:
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Living w/partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily Amount/day: _____	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily Amount/day: _____	<input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit: _____ <input type="checkbox"/> Currently smoking ____ packs/day	<input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Regularly <input type="checkbox"/> Daily Type of exercise: _____	<input type="checkbox"/> 6-8 hours <input type="checkbox"/> Insomnia <input type="checkbox"/> Wake up too early <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Dreamer	<input type="checkbox"/> Fumes <input type="checkbox"/> Dust <input type="checkbox"/> Solvents <input type="checkbox"/> Airborne particles <input type="checkbox"/> Noise <input type="checkbox"/> Vaccinations

Drug use:  Never  Type/frequency \_\_\_\_\_

Special Diet:  Yes if so, type: \_\_\_\_\_

**Family Medical History**

	Age	Diseases	Date deceased, cause of death
Spouse	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

Who do you see for Medical Doctors? \_\_\_\_\_

# Alpenglow Acupuncture, LLC

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

## Constitutional Symptoms

- General health the past year
  - Good  Poor
- Recent weight change \_\_\_\_\_
- Fever
- Fatigue / Poor Energy
- Sleep problems / snoring

## Eyes

- Eye disease or injury
- Wear glasses or contacts
- Eye Surgery \_\_\_\_\_
- Blurred or double vision

## Ear/Nose/Mouth/Throat

- Hearing loss or ringing of ears
- Ear pain or drainage
- Ear Infections
- Sinus Infections / Problems
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Sore throat or voice change
- Swollen glands in neck

## Cardiovascular

- Last cholesterol screen
  - Date \_\_\_\_\_ Total \_\_\_\_\_
  - LDL \_\_\_\_\_ HDL \_\_\_\_\_
  - Triglycerides \_\_\_\_\_
- Heart trouble / attack
- Chest pain / angina
- Heart medications
- Blood thinner medications
- Hear Murmur
- High blood pressure
- Shortness of breath walking
- Pain in legs with walking
- Shortness of breath at rest
- Swelling of feet or ankles
- Varicose veins
- Cold Extremities

## Respiratory

- Cough
- Shortness of breath
- Wheezing / Asthma
- Inhaler use
- Coughing up blood
- Tobacco use or exposure

## Gastrointestinal

- Colon cancer screen
  - Date: \_\_\_\_\_
- Appetite  Good
  - Poor  Excessive
- Change in appetite recently
- Nausea or vomiting
- Heartburn / Reflux
- Abdominal Pain
- Bloating
- Fatigue after eating
- Bowel movements:
  - #/day \_\_\_\_\_  Easy  Hard
- Skip days of moving bowels
- Constipation
- Loose stool or diarrhea
- Painful bowel movements
- Change in bowel habits
- Rectal bleeding or blood in stool

## Musculoskeletal / Pain

- Muscle aches or cramping
- Joint pain or stiffness
- Joint swelling
- Low Back Pain
- Neck Pain
- Difficulty Walking or Standing
- Osteoporosis - Bone Scan \_\_\_\_\_
- History of Injuries and Accidents
- Date: \_\_\_\_\_
- Date: \_\_\_\_\_

## Neurological / Psychological

- Headaches
  - Daily  Weekly  Rarely
- Migraines
- Sinus headaches
- Tension headaches
- Dizziness or Light headed
- Convulsions or seizures
- Tremors
- Paralysis
- Numbness or tingling
- Depression
- Anxiety / Nervousness
- Memory Loss / Confusion
- Abuse Survivor

## Genitourinary

- Frequent urination
- Nighttime urination
- Urgency / burning / painful urination
- Blood in urine
- Change in urine stream
- Incontinence or dribbling
- Kidney stones
- Sexual difficulty
- Male: Testicle Pain
- Male: Last PSA \_\_\_\_\_  
Prostate Check \_\_\_\_\_

## Female:

- Last Menstrual Period \_\_\_\_\_
- Menses LMP \_\_\_\_\_
  - Regular  Irregular
  - Menopausal
- Length of Menses \_\_\_\_\_ # of days
- Monthly Cycle \_\_\_\_\_ # of days
- PMS  Irritability  Fatigue
  - Emotional
  - Breast Tenderness/Swelling
  - Other \_\_\_\_\_
- Vaginal discharge or itching
- # Pregnancies \_\_\_\_\_
- # Live Births \_\_\_\_\_
- Menopause Symptoms:
  - Hot flashes  Night sweats
  - Dryness
  - Other \_\_\_\_\_
- Date last Mammogram \_\_\_\_\_
  - Normal  Abnormal
- Date last Pap Smear \_\_\_\_\_
  - Normal  Abnormal

## Integumentary (Skin / Breast) /

### Immune System

- Rash, itching, hives
- Dry skin
- Eczema or Psoriasis
- Change in skin, hair or nails
- New or changing moles
- Breast pain or discharge
- Breast lump
- Allergies:  Food  Seasonal
  - Environmental
- Immune Deficiency/Compromise