American Health Acupuncture
235 W Giaconda Way Suite 233 Tucson AZ 85704 (520) 544-6603

Notes for new Patients: Your first session

* Can you imagine not having to wait at a doctor's office? Well, your time is as valuable as ours.
We have a no-wait policy. You will be seen within minutes of your arrival.

- Whenever possible, arrange your schedule so you do not have to rush to or from your appointment.
- We kindly ask that you refrain from wearing cologne or perfume when coming in for treatments.
- Please eat a little something an hour or two before your appointment.
- Please leave all cell phones in your car. Wear loose, comfortable clothing if possible. Ideally, there should be easy access to your legs up past the knee, arms past the elbows, and abdomen. Feel free to bring such clothes to change into before your treatment.
- If you wear Contact Lenses, please bring some solution and a case, as you may be asked to remove them for the Iridolgy exam.

Name______________________________________ Birth date____________ Age____ Sex_______

Address___________________________________ City__________________ State____ Zip______

Telephone (Home) ____________________ Telephone (Cell)______________________________

E-mail Address____

Have you been treated by Acupuncture or Oriental Medicine before? __________

Referred to us by: ____

CONSENT:

I,________________________ hereby voluntarily consent to be treated by acupuncture and/or other Oriental Medicine modalities preformed by American Health Acupuncture practitioners.

Patient's Signature____Date____________________

Your Health Care Provider/MD? ____________________________ Phone ____________________

In Emergency Notify______________________________________ Phone ____________________

Main Problem ____
Is this visit the result of an accident or injury? Yes · No · If yes, please explain ______
____
How long ago did this problem begin?____
Have you been given a diagnosis for this problem? If so, What?__________________________
____
What kinds of treatment have you tried?____
Are you currently receiving treatment for your problem? ____ If so, please describe:________
____
Does anything improve your problem?____

Past Medical History (please include date):
Illnesses:____
____
Surgeries:____
Significant Trauma (auto accidents, falls, etc.):____

Do you have, or have you ever had, any infectious diseases?________If so, please describe:___

Medicines: (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months ____
____
Allergies: ____
Family Medical History (General Health):
Mother's side: ____
Father's side: ____
Number of siblings: _________ If above deceased, cause of death: ________________________
Personal birth history: (prolonged labor, forceps delivery, etc.) _____________________________
____
Current Emotional Health: ____
Current Quality of Life: ____
Current Relationship/Quality: ____
Current Predominant Emotion: ____
Occupation: ___________________________________ Stress level_______________________
Have you had any unusual stresses recently? ____
____
Favorite time of year: _______________________ Worst time of year_____________________

Hobbies and Recreational Habits: ____

Do you have a regular exercise program? _______ Please describe:______________________

____

Travel abroad within the past year? _____ Where?______________________________________

Have you ever been on a restricted diet? _____________ Please describe:_________________

Please describe your average daily diet:
Morning Afternoon Evening
____
____
____
Proportion of raw food __________________to cooked food_________________________________
Do you get any cravings? _____ If so, what? ____
When? ___________ Preferred Tastes:________ Bitter ☐ Spicy ☐ Sour ☐ Salty ☐ Sweet ☐
How many packs of cigarettes do you smoke a day? ____________________________________
How much coffee, tea or cola do you drink per week? __________________________________
How much alcohol do you drink per week? ____

Do you or your family, have a history of any of the following?

- ☐ Cancer
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Allergies
- ☐ Thyroid Disorders
- ☐ Heart Disease
- ☐ HIV
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Herpes
- ☐ Addictive Disorders
- ☐ Stroke
- ☐ Hepatitis
- ☐ Mental Illness

Put a check mark by the symptoms that pertain to you over the last month.

- ☐ Cold hands
- ☐ Cold feet
- ☐ Fatigue
- ☐ Feverish in the
- ☐ afternoon or flushes
- ☐ Heat sensation in hands, feet, chest
- ☐ Day sweats
- ☐ Night sweats
- ☐ Thirsty
- ☐ Catch colds easily
- ☐ Shortness of breath
- ☐ Sweat easily
- ☐ General weakness
- ☐ Feel worse after exercise
- ☐ Dizziness
- ☐ See floating black spots
- ☐ Poor balance
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Swelling of hands
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Anxiety
- ☐ Chest pain traveling to shoulder
- ☐ Insomnia
- ☐ Dream disturbed sleep
- ☐ Mental confusion
- ☐ Emotional changes
- ☐ Cough
- ☐ Cough blood
- ☐ Nasal discharge
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Dry mouth, throat, nose, nose or skin
- ☐ Sore in lips, tongue
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Allergies
- ☐ Chills alternating with fever
- ☐ Sneezing
- ☐ Headache
- ☐ Feel achy
- ☐ Stiff neck/shoulders
- ☐ Sore throat
- ☐ Difficult breathing
- ☐ Fever
- ☐ Chills
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Phlegm, color___________
- ☐ Low appetite
- ☐ Change in appetite
- ☐ Loose stools, diarrhea
- ☐ Constipation
- ☐ Abdominal bloating and/or gas after eating
- ☐ Fatigue after eating
- ☐ Prolapsed organs (previously diagnosed)
- ☐ Bruise easily
- ☐ General feeling of heaviness in body
- ☐ Mental heaviness, sluggishness or fogginess
- ☐ Swollen hands/feet
- ☐ Chest congestion
- ☐ Nausea
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Indigestion
- ☐ Ulcers
- ☐ Hernia
- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad breath
- ☐ Mouth (canker) sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Belching
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Diarrhea alternating with constipation
- ☐ Feel better after exercise
- ☐ Chest pain
- ☐ Tight feeling in chest
- ☐ Bitter taste in mouth
- ☐ Blood shot eyes
- ☐ Anger easily
- ☐ Skin rashes

- ☐ Headache at top of head
- ☐ Hot flashes
- ☐ Dry eyes
- ☐ Numbness of hands and feet
- ☐ Muscle spasms, twitching, cramping
- ☐ Seizures
- ☐ Tremors
- ☐ Convulsions
- ☐ Irritability; easily susceptible to stress

Put a check mark by the symptoms that pertain to you.

- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination (urgent urination☐)
- ☐ Do you get up more than once at night to urinate?
- ☐ Lack of bladder control
- ☐ Memory problems
- ☐ Ringing in the ears
- ☐ Genital sores
- ☐ Kidney stones

Urine is:

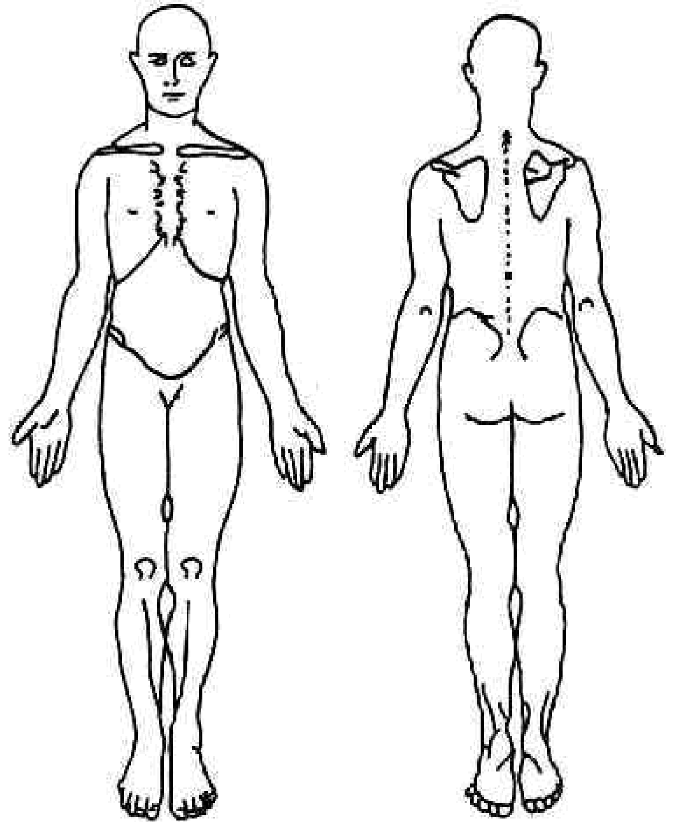
- ☐ Normal color
- ☐ Cloudy
- ☐ Difficult
- ☐ Scanty
- ☐ Urgent
- ☐ Has odor
- ☐ Clear
- ☐ Dark yellow
- ☐ Reddish
- ☐ Burning
- ☐ Painful
- ☐ Spasms
- ☐ Recent sprains
- ☐ Injuries or falls
- ☐ Joint Pain

Libido (sexual drive) is:

- ☐ Normal__ Low __High __
- ☐ Depression
- ☐ Mania
- ☐ Weight loss
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Phlebitis
- ☐ Blood clots
- ☐ Parasites
- ☐ Poor hearing
- ☐ Concussion
- ☐ Itching
- ☐ Eczema
- ☐ Hives
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Dry skin
- ☐ Rash
- ☐ Recent moles

Musculoskeletal:

- ☐ General aches
- ☐ Muscular atrophy
- ☐ Muscular weakness
- ☐ Arthritis
- ☐ Joint instability
- ☐ Muscle cramps



Please c**ircle** on the diagram any areas of any type of pain or injury. Please try to describe the type and quality of the pain. ☐ sharp ☐ burning ☐ aching ☐ pressure-like ☐ crampy ☐other__________________________

How are you today? (Scale of 1-10)

Great OK Bad

I0_______________5_______________1

How committed are you to getting well?
(10 is 100% Committed.)

0_______________5 _______________10

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Other ___________________________

WOMEN ONLY

Please answer each question or check as appropriate.

Are you pregnant? Yes ☐ No ☐
Number of children_____
Number of pregnancies _____
Your age at first period _____

Are your menses cycles regular?
Yes☐ No☐

Number of days between periods? _______
Average days of flow? _______
The flow is:
☐ Normal ☐ Heavy ☐ Light
The color is:
☐ Normal ☐ Dark ☐ Pale
☐ Bright red ☐ Brown
Are there blood clots: ☐ Yes ☐ No

Do you have pain/cramps?
☐ Yes ☐ No
☐ Before ☐ During or ☐ After period

Do you have nausea or vomiting?
☐ Yes ☐ No ☐Before ☐ During

Do you experience any of the following before your period each month?
☐ Water retention ☐ Breast tenderness
☐ Breast swelling ☐ Irritability
☐ Mental depression
☐ Food cravings ☐ Low back pain
☐ Migraines

Do you bleed between periods?
☐ Yes ☐ No

Do you have vaginal discharge between periods?
☐ Yes ☐ No
If yes, describe consistency, color, and smell
____

MEN ONLY

Please check questions as appropriate

☐ Feeling of coldness or numbness in the external genitalia?

☐ Pain or swelling of testicles?

☐ Premature ejaculation?

☐ Impotence?

☐ Number of children? _________

By signing your name in the space provided below, affirms you have read and received a copy of the American Health Acupuncture's Notice of Privacy Practices, Payment, Cancellation, & Refund Policies and agree to its terms.

Signature of Patient:

Name: ____ **Date:** ________________

Signature is Required.