PULSE ACUPUNCTURE P.C.

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Please note that all information is strictly confidential. Please complete as thoroughly as possible.

Appointment Date:_____

General Information

First Name:	Last Name:	Date of Birth:	Age:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Email address:	Email appt. reminders: □Yes □ No	Text reminders: □Yes □No	Phone reminders: □Yes □No
Marital Status: □Single	□Married	□Partnered	□Divorced □Widowed
Emergency Contract:	Relationship	Phone	
Employment Status: (all that apply) □Full-Time □Part-Time	□Self-Employed	□ Retired	□Unemployed □ Student
How did you hear about us? □Friend □Current Patient	□Walk-In	□Doctor	□Insurance □Internet
Who we may thank for referral?_____			

May we correspond with you (invoices, questions, etc.) via email: □Yes □No
If not how shall we correspond with you?_____
Have you had acupuncture treatment before? □Yes □No If yes for what condition?_____

Employment and Insurance Info

Occupation:	Name of employer:	Employer's Address:	
Patient's Primary Insurance:	Policy ID#:	Patient's SS#:	Group#:
Primary Policy Holder Name:	Primary Policy Holder DOB:	Relationship to patient:	
Patient's Secondary Insurance:	Policy ID#:	Group#:	
Secondary Policy Holder Name:	Secondary Policy Holder DOB:	Relationship to patient:	

Focus

What is your primary reason for seeking care at our office?

When did it begin?_____

What makes it worse?_____

What makes it better? _____

What treatments have you had for this condition?_____
Name of Primary Physician: _____ Phone Address _____
Are you interested in:
□Pain Relief □Maintenance Care □Preventative Care □Chinese Herbs □Oriental Nutrition □ Lose Weight
□ Other

Personal Medical History

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Addiction	○	○		Chronic Fatigue	○	○		STI	○	○	
AIDS/HIV				Chronic Pain	○	○		Stroke	○	○	
Allergy:				Cancer	○	○		Thyroid	○	○	
Seasonal Allergy	○	○		Type:				Hyperactive	○	○	
Food Allergy	○	○						Hyporactive	○	○	
Dust/mold Allergy	○	○						Lyme			
Anemia	○	○		Diabetes	○	○		Epilepcy	○	○	
Arthritis	○	○		Deverticulitis	○	○		Weight Gain	○	○	
Asthma	○	○		Emphysema	○	○		Mental Illness	○	○	
Acne	○	○		Heart Disease	○	○		Insomnia	○	○	
Asthma	○	○		Herpes	○	○		Muscle Cramps	○	○	
Bad Breath	○	○		High Cholesterol	○	○		Multiple Sclerosis	○	○	
Breast lump/pain	○	○		Hyperglacemia	○	○		Pacemaker	○	○	
Bruise Easily	○	○		Hypertension	○	○		Auto-Immune Disorder	○	○	

Sleep

Difficulty Falling Asleep□ Difficulty Staying Asleep□
Dream Disturbed Sleep□ Excess Sleep□
Not rested upon waking□ Restless Sleep□
Wake / at Night Time_____
Sleep hours_____

Energy

Dependent on Coffee□ Chronic Fatigue□
Drops After Eating □ Body Feels Heavy□
Sudden Energy Drop□ Body Feels Weak□
Time of Day?_____

Neurological/Emotional and Psychological

Vertigo/Dizziness □ Anxiety □ Irritable □ Joy □ Depressed □
Nervousness □ Poor Memory □ Grief □ Tremors □ Fearful □
Bi-Polar □ Poor Concentration □ Over-thinking □ Loss of Balance □ Indecision □
Anger□ Difficulty Expressing Emotions□ Frequent sighing or yawning □ Areas of Numbness □ Easily Stressed □
Sadness □ Forgetful □ Temper □
Seasonal Affective Disorder □ Over-thinking □

Temperature & Thirst

Cold hands and Feet □ Cold "in bones" □ Chills □
Hot Hands□ Hot feet□ Hot Chest □
Hot Flashes □ Hot at Night □ Hot in afternoon □
Night Sweats □ Spontaneous sweats □ Unusual Sweats? Where?_____ What time?_____
Thirst for cold drinks □ Thirst for hot drinks □ Thirst, No desire to drink □ No Thirst □ Excess Thirst □

Head, Eyes, Ears, Nose, Throat

Migraine □ Headache □ Feeling lightheaded/dizzy□
Red/Itchy Eyes □ Floaters □ Blurry Eyes □ Eye Strain □
Dry Throat □ Dry Lips □ Mouth Sores □ Tongue Sores □
Poor Smell □ Earaches/Itchiness□ Tinnitus □ Poor Hearing □
Nose Bleeds □ Sinusitis□ Nasal Discharge □ Deviated Septum □
Difficulty Swallowing □ Grinding Teeth □ TMJ / Jaw Pain□ Bleeding Gums □

Respiratory

Frequent Colds/Flu □ Frequent Fevers □ Productive cough □ Dry Cough □ Chronic Cough □
Chest Tightness □ Shortness of Breath □ Empysema □ Phlegm□ Color _____
Asthma □ Bronchitis □ Difficulty Inhaling □ Difficulty Exhaling Pain on Deep Breath□

Skin, Hair, Nails

Rashes	□	Eczema	□	Psoriasis	□	Dermatitis	□	Acne	□
Hives	□	Itching	□	Warts	□	Abscesses/Infections	□	Ulcerations	□
Thick skin	□	Thin Skin	□	Scaly skin	□	Discolored skin	□	Ulcerations	□
Hair Loss	□	Dandruff	□	Dry/Brittle Hair	□	Premature Graying	□		□
Face Flushing	□	Lumps	□	Dark under eyes	□	Other	□		□
Thin Nails	□	Dry Nails	□	Brittle Nails	□	Ridged nails	□	Nail Fungus	□

Cardiovascular

Palpitations	□	Slow heart rate	□	Elevated heart rate	□	Irregular heart beat	□
High Blood Pressure	□	Low blood pressure	□	Fainting	□	Hands/feet swelling	□
Bleed/Bruise Easily	□	Blood clots	□		□	Chest/Pain Swelling	□

Gastrointestinal

Bowel Movement (BM) :		How Often?__x/days(s)		Formed? Yes □ No□		Cramps with BM?	Difficult BM?
Dry Stool	□	Diarrhea	□	Constipation		Incomplete BM □	Foul Smell □
Undigested Food	□	Mucus	□	Blood in Stools		□	□
Hemorrhoids	□	Indigestion	□	Belching		Gas □	Heartburn/Reflux □
Abdominal Pain	□	Rectal Pain	□	IBS/Chrohn's Disease		Bloating □	□
Poor Appetite	□	Excessive Appetite	□	Weight Gain		Weight Loss □	Lump in Throat □

Urogenital

Clear Urine	□	Dark Urine	□	Cloudy Urine		Blood in Urine □	□
Incontinence	□	Frequent Urination	□	Urgent Urination		Painful Urination □	Burning Urination □
Difficult to Start	□	Slow Flow	□	Incomplete Urination		Frequent UTI □	Wake up to Urinate □
Decreased Libido	□	Premature ejaculation	□	Nocturnal Emission		Testicular pain □	Genital pain □
Excess Libido	□	Genital Sores	□			Herpes □	Vasectomy □

Gynecological

Are you currently pregnant? □Yes □ No Are you currently trying to get pregnant? Yes □ No □ Stopped Menses? Age

If experiencing menopausal symptoms, please describe:

Age of first menses: Date of last menses: Length of Cycle:

Average number of Days Flow Flow is Light □ Normal □ Heavy□

Color (in the beginning of menses): Pale □ Dark red □ Bright Red □ Brown □ Are clots present? □Yes □ No

Does your period cause cramping or pain? Yes □ No□ When? Before □ During□ After Period □

Do you get nausea or vomiting □Yes □ No

Do you get any of the following before your period each month:

Water Retention □ Food Cravings □ Irritability □ Break outs □ Fatigue □ Low Back □

Migraines □ Depression □ Breast Tenderness □

Date of Last Pap smear:_____ Ever Had Abnormal pap smear? Yes □ No□ When/Why? _____

Number of Pregnancies _____ Number of births?_____ # of miscarriages _____

Vaginal Dryness □ Vaginal Sores □ Vaginal pain□ Vagina Discharge □ Yeast Infections □ Uterine Fibroids or polyps □

Painful Sex □ Endometriosis □ Pelvic Inflammatory Disease □

PCOS □ Ovarian Cysts □ Fibrocystic Breast Tissue□

List any past or future surgeries _____

List any significant trauma. When did it occur? (auto accident, work related, emotional, sexual, etc.)_____

_____

List exercise and sport activities you have been or are currently involved in: _____

_____

Musculoskeletal/Extremities

Please List your PAINS and Pain level:

HEAD □	NECK □	SHOULDER □	Joint Swelling □	Edema □	Carpal Tunnel □
LOW BACK □	MIDDLE BACK □	UPPER BACK □	Broken Bones □	Tendonitis □	Sprains/Strains □
TOES □	FEET □	ANKLES □	Bone Deformity □	Muscle pain □	Whole Body Pain □
FINGER/S □	WRIST/S □	HANDS □	Paralysis □	Bursitis □	Rotator Cuff □
ELBOWS □	SHOULDERS □	ARMS □	Sciatica □	Limited mobility □	Poor Balance □
Lower Bag □	Hips □	Pelvis □	Other □	□	□

Pain

Please indicate intensity of pain :

□	No Pain	□	Moderate Pain	□	Severe Pain	□	Terrible Pain
	Sleeping as result of pain:						
□	No Problem	□	Mildly Disturbed	□	Greatly Disturbed	□	Cannot Sleep
	Work Can do:			□		□	
□	Usual Work	□	25% of Work	□	50% of Work	□	No work
	Frequency of Pain:						
□	25 % of time	□	50% of time	□	75% of time	□	100% of time
	Travel						
□	No problem on long trips	□	Moderate pain on trips	□	Severe pain	□	
□	Recreations –Can do:	□		□		□	
□	All Activities	□	Some Activities	□	No Activities	□	
	Walking						
	☐ Can Walk any distance		☐ Pain After ½ mile		☐ Cannot Walk		
	Sitting						
	☐No Pain Sitting		☐ Some pain while sitting		☐ Cannot Sit		

Lifestyle:

Diet: Please check all that apply to your diet ⇨

□	Low fat
□	Vegetarian
□	Standard American
□	Low Carb
□	Vegan

Any food cravings?

Typical Breakfast
Typical Lunch
Typical Dinner
Typical Snack

What is your favorite taste? Sweet □ Spicy □ Salty □ Sour □

What is your favorite color?_____

What are your hobbies/pleasures?_____

Patient Signature_____