Live Well Acupuncture
Tolley Sink, L.Ac.

303. 775. 1456
TolleySink@gmail.com

PATIENT INFORMATION

General Information

Name ____________________ Date ____________________

Address ____________________

City ____________________ State __________ Zip code ____________________

Best contact phone number ____________________

Email address ____________________ Occupation ____________________

Gender: **F** **M** DOB __________

Emergency contact person ____________________

Phone ____________________

Name of primary care physician ____________________

Referred by ____________________

Had acupuncture before? __________ Taken Chinese herbs before? __________

Main complaint

What is your primary reason for seeking treatment? ____________________

____

When did it begin? ____________________

What makes it worse? ____________________

What makes it better? ____________________

What diagnoses have you been given? ____________________

What other forms of treatment have you tried? ____________________

What other health concerns do you have? ____________________

Health History

How would you describe your health as a child? ____________________

____

How is your sleep? ____________________

____

How is your digestion? ____________________

____

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Health History Continued

What is your typical daily diet? ______________________________

____

Please list any accidents, surgeries or hospitalizations? ______________________________

____

Please list any allergies or sensitivities to any medications or other substances ______________________________

____

Please check any conditions you have now or have had in the past:

Alcoholism	Glaucoma	Multiple sclerosis
Allergies	Heart disease	Pacemaker
Asthma	Hepatitis	Pneumonia
Cancer	High fever	Stroke
Chronic fatigue	HIV/AIDS	STD
Diabetes	Hypertension	Thyroid disorder
Drug addiction	Jaundice	Tuberculosis
Epilepsy	Kidney disease	Ulcers
Fibromyalgia	Mental illness	

Please list any medications and/or supplements that you are currently taking:

Medication/ Supplement	Dose	Reason

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Survey of Symptoms: Please check any that you currently experience

Excessive appetite	Palpitations	Shortness of breath
Loose stool/ diarrhea	Tight feeling in chest	Decreased sense of smell
Indigestion	Nightmares	Nasal problems
Vomiting	Mental restlessness	Skin problems
Belching and burping	Laughter without reason	Pain or cold in genital area
Heartburn/reflux	Chest pain	Bronchitis
Hay fever	Hemorrhoids	Constipation
Low back pain	Frequent urination	Numbness
Tongue sores	Cold hands/ feet	Low libido
Fatigue	Abdominal pain	Dizziness
Edema	Sciatic pain	Faint easily
Blood in stool	Headaches	High cholesterol
Easy bruising	Claustrophobia	Sudden weight loss
Prostate conditions	Sudden weight gain	Catch colds easily
Eye problems	Gallstones	Trouble with weather changes
Difficulty making decision	Easily angered/ agitated	Allergies
Soft/ brittle nails	Bloating	Ear ringing
Night sweats	Sweat easily	Stiff shoulders
Sore throat	Dry throat	Difficult breathing
Memory problems	Muscle spasms	

Is there anything else you would like me to know?____

____

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____

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____

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Females

Are you pregnant now? **Y** **N**

Number of children __________ Number of pregnancies _____________

Age of first period ___________ Age of menopause _________________

Number of days between period ______ Number of days of flow ______

Flow is normal heavy light

Color is normal dark purple brown

Do you have any of the following symptoms or conditions?

Blood clots	Cramps	Nausea
Breast distention	PMS	Bleeding between periods
Heavy vaginal discharge	Endometriosis	Fibrocystic breasts
Ovarian cysts		

All medical information is confidential.

All the information given on this form is true and accurate, and I hereby consent to and authorize treatment by the practitioner at **Live Well Acupuncture**.

Patient signature ____ Date _________________________

Consent to treat a minor (name)____

Parent/ legal guardian signature ____