element
natural healing arts

Acupuncture Patient Information

Name:_____ Tel. No. (h): _____(w):_____(c):_____
Email:_____Address:_____ Apt:____ City:_____
State: _____Zip Code:_____ DOB:___/___/___ Age:_____ Sex: _____ Ht: _____Wt:_____
Marital Status: _____ No. of Children:_____
Occupation:_____ Employer: _____
Primary Physician: _____Physician Phone: _____
Emergency Contact Name:_____ Phone:_____ Relationship to You:_____
How did you hear about us?/Referred by: _____
Would you like to receive emails about specials and classes from Element Natural Healing Arts ? ☐ Yes ☐ No

Insurance Information:

Insurance Company Name:_____ Address: _____
Policy No:_____ Policy Holder's Name: _____ Policy Holder's Phone:_____
Policy Holder's Address:_____ City:_____ State:_____ Zip: _____
Policy Holder's DOB: ___/___/___Insurance Company Phone No. for Providers:_____

Present History

Main concern you would like me to help you with: _____
Other relevant complaints: _____
Is this the result of an accident or injury? ___Yes ___No Explanation of accident _____
When was the first time you were aware of the condition, when and how did it start?_____
_____
Have you been given a diagnosis for this condition? If so, what? _____
What kind of treatment(s) have you tried for this condition? _____
What makes it better?_____ What makes it worse?_____
Have you had acupuncture before?_____ If so, for what?_____

Medical History

Current medicinals/ supplements:_____
Previous surgeries: _____
Have you ever been advised to have a surgery that was not done? _____
Have you ever been hospitalized? If so, explain:_____
Allergic to any medications? _____Other known allergies? _____
Are you currently pregnant? ___Yes ___No (How far along? _____)Date of last menstrual cycle? _____
(Please inform your acupuncturist if at any time you think you may be pregnant.)

Have you ever had or do you currently have:

☐Anemia	☐Arthritis	☐AIDS	☐Cancer	☐Carpal Tunnel
☐Convulsions	☐Diabetes	☐Digestive disorders	☐Epilepsy	☐Epstein-Barr
☐Fibromyalgia	☐German Measels	☐Heart Trouble	☐Hepatitis A/B/C	☐HIV
☐Lupus	☐Multiple Sclerosis	☐Pacemaker	☐Parkinson's Disease	☐PCOS
☐Polio	☐Rheumatic Fever	☐Scarlet Fever	☐Thyroid condition	☐Tuberculosis

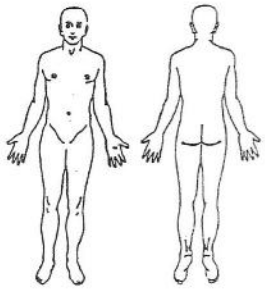
Other: _____

Family History - *Has anyone in your immediate family ever had:*

☐Alcoholism	☐Allergies	☐Arthritis	☐Asthma	☐Cancer
☐Diabetes	☐Drug Problem	☐Epilepsy	☐Glaucoma	☐Heart Trouble
☐High Blood Pressure	☐Kidney Disease	☐Mental Disorder	☐Scoliosis	☐Stroke
☐Tuberculosis	☐Ulcers	Other: _____		

If you are experiencing pain, mark the area of your pain with the associated symbols:

++++++ Sharp and Stabbing
000000 Pins and Needles
VVVV Achy
///////// Numbness



Patient's Signature: _____

Date: _____

element
natural healing arts

Patient Information:

Patient Name: _____

Lifestyle

☐Alcohol ☐Tobacco ☐Marijuana ☐Drugs ☐Stress ☐Exercise Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

☐Poor appetite	☐Big appetite	☐Recent weight gain/loss	☐Fatigue after eating	☐General fatigue
☐Numbness	☐Lack of strength	☐Body feels heavy	☐Strongly like cold drinks	☐Strongly like hot drinks
☐Poor sleep	☐Heavy sleep	☐Cold hands or feet	☐Poor circulation	☐Shortness of breath
☐Fever	☐Chills	☐Night sweats	☐Sweat easily	☐Muscle cramps
☐Vertigo/ dizziness	☐Bleed, bruise easily	☐Peculiar taste (describe)_____		

Head, Eyes, Ears, Nose, Throat

☐Headaches	☐Migraines	☐Poor vision	☐Glasses	☐Eye strain
☐Eye pain	☐Red Eyes	☐Itchy eyes	☐Blurred vision	☐Night blindness
☐Glaucoma	☐Cataracts	☐Teeth problems	☐Grinding teeth	☐TMJ
☐Facial pain	☐Gum problems	☐Dry mouth	☐Excessive saliva	☐Sores on lips on tongue
☐Sinus problems	☐Recurrent sore throat	☐Swollen glands	☐Enlarged thyroid	☐Nose bleeds
☐Poor hearing	☐Ear ringing	☐Ear popping	☐Earaches	☐Concussions
☐Loss of smell	☐Change in taste			

☐Head or neck problems (explain)_____ ☐Excessive phlegm (color)_____

Respiratory

☐Shortness of breath ☐Asthma/wheezing ☐Tight chest ☐Pneumonia ☐Coughing blood
☐Difficulty breathing when lying down ☐Cough recurrent?_____ wet/dry_____thick/thin_____phlegm/color_____

Cardiovascular

☐High blood pressure	☐Low blood pressure	☐Chest pain	☐Tachycardia	☐Heart palpitations
☐Blood clots	☐Fainting	☐Difficulty breathing	☐Phlebitis	☐Irregular heartbeat

Gastrointestinal

☐Nausea	☐Vomiting	☐Acid regurgitation	☐Gas	☐Bad breath
☐Hiccup	☐Bloating	☐Diarrhea	☐Constipation	☐Laxative use
☐Black stools	☐Bloody stools	☐Itchy anus	☐Rectal pain	☐Hemorrhoid
☐Anal fissures	☐Mucous in stools	☐Intestinal pain or cramping		

Bowel Movements: frequency_____texture/form_____ color_____ odor_____

Musculoskeletal

☐Neck/shoulder pain	☐Joint pain	☐Low back pain	☐Upper back pain	☐Muscle pain
☐Spinal curvature	☐Walking problems	☐Rib pain	☐Muscular Atrophy	

☐Other (explain)_____

Skin and Hair

☐Rashes	☐Eczema	☐Acne	☐Hives	☐Psoriasis
☐Dandruff	☐Ulcerations	☐Itching	☐Oozing lesions	☐Hair loss
☐Fungal infections	☐Other hair or skin problems_____			

Neuropsychological

☐Seizures	☐Depression	☐History of abuse	☐Anxiety	☐Considered/attempted suicide
☐Easily stressed	☐Tics	☐Irritability	☐Poor memory	☐Obsessive/compulsive behavior
☐Seeing a therapist	☐Other_____			

Genito-urinary

☐Pain with urination	☐Frequent urination	☐Urgent urination	☐Blood in urine	☐Unable to hold urine
☐Incomplete urination	☐Venereal disease	☐Bedwetting	☐Wake to urinate	☐Kidney stone
☐Increased libido	☐Decreased libido	☐Impotence	☐Premature ejaculation	☐Nocturnal emission

Gynecology

Age menses began_____ Date of last period_____ Length of cycle_____ Duration of flow_____ Color of blood_____
☐Vaginal discharge (color)_____ Date of last PAP_____ ☐Irregular periods ☐Painful periods
☐PMS ☐Vaginal odor ☐Vaginal sores ☐Clots ☐Breast Lumps
# of pregnancies_____ # of miscarriages_____ # of abortions_____ # of premature births_____ Onset of menopause (age) _____

Other_____

518 Henry Street, Brooklyn • phone 718.855.4850 fax 718.855.4860 • elementhealing.com