Welcome to Whole Cosmos Acupuncture

Sally Adams, RN, Licensed Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. General Patient Information

Name: _____ Date: _____/_____/_____

Address: _____

City, State, Postal Code: _____

Phone: Home (_____)_____ Cell (_____)_____ Work (_____)_____

Email Address: _____ Age: _____ Date of Birth: _____/_____/_____

Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Partnered Social Security Number: _____-_____-_____

Occupation:_____ Employer:_____

Emergency Contact _____ Relationship _____

Phone of Emergency Contact _____Name of Primary Physician _____

Who can we thank for having referred you? Friend/Referral _____

❑ Walk In/Drive By ❑ Medical Doctor ❑ Phone book ❑Internet

☯☯☯

Major Complaint(s), in order of significance to you:

_____

_____

My concerns are a result of: ❑ Auto Accident ❑ Job Related ❑ Injury ❑ Other_____

How do these conditions impair your daily activities?

_____

_____

II. Patient Medical History

How was your childhood health?

_____

Recent tests: (please indicate test results and date below)

❑Physical	❑Cholesterol	❑Prostate	❑Blood (which?) _____
❑HIV/STD	❑Pap smear	❑Mammography	❑Other:_____

Test Results and Date:_____

Check any you have had in the past:

❑Diabetes	❑Allergies	❑Glaucoma	❑Rheumatic Fever
❑Heart Disease	❑CVA (stroke)	❑Vein condition	❑Thyroid disorder
❑Asthma	❑Pneumonia	❑Tuberculosis	❑Emphysema
❑Jaundice	❑Gonorrhea	❑Mumps	❑Bleeding tendency
❑Syphilis	❑Measles	❑Chicken pox	❑Nervous disorder
❑Meningitis	❑HIV	❑Polio	❑Mononucleosis
❑Epilepsy	❑High fever	❑Hepatitis	❑Multiple Sclerosis
❑Paralysis	❑Cancer	❑Migraines	❑High blood pressure

Immunizations:_____

Surgeries (Please list types and dates):

_____

_____

_____

_____

My current medications/Herbs/Supplements are:

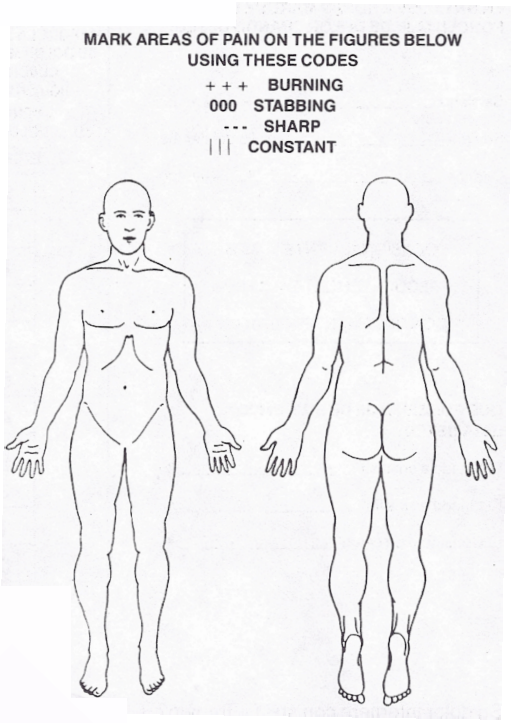
_____

_____

_____

III. Patient Profile

Please mark areas of your body where you have pain on the image to the right ---------->



The pain feels:
❑Sharp ❑Burning ❑Aching
❑Cramping ❑Dull ❑Moving
❑Fixed ❑Other:_____

The pain feels better with:
❑Pressure ❑Cold ❑Heat
❑Rest ❑Exercise
❑Other:_____

The pain feels worse with:
❑Pressure ❑Cold ❑Heat
❑Rest ❑Exercise
❑Other:_____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):
❑Cold hands ❑Cold fingers ❑Cold feet ❑Cold toes
❑Sweaty hands ❑Sweaty feet ❑Afternoon flushes ❑Night sweats
❑Heat in the hands, feet, and chest ❑Hot flashes any time of the day
❑Thirsty ❑Perspire easily ❑Lack of perspiration
❑Take water to bed

Overall energy (Lung, Kidney function):
❑Shortness of breath ❑Low energy ❑General weakness
❑Easily catch colds ❑Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):
❑Dizziness ❑See floating black spots ❑ Overall cold sensation

Heart function:
❑Palpitations ❑Anxiety ❑Sores on the tongue
❑Restlessness ❑Mental confusion ❑Chest pain traveling to shoulder
❑Frequent dreams ❑Wake tired ❑Drink coffee (# of cups per week: _____)

Lung function:
❑Nasal Discharge (Color: _____) ❑Cough
❑Nose Bleeds ❑Sinus Congestion ❑Dry mouth ❑Sore throat
❑Dry Nose ❑Dry Skin ❑Allergies (To what? _____)
❑Sneezing ❑Overall achy feeling in the body
❑Difficulty breathing ❑Smoke cigarettes (# of cigarettes per day: _____)
❑Sadness ❑Melancholy

Spleen function:
❑Low appetite ❑Abrupt weight gain ❑Abrupt weight loss
❑Abdominal bloating ❑Abdominal gas ❑Fatigue after eating
❑Prolapsed organs (previously diagnosed, which organ? _____)
❑Easily bruised ❑Hemorrhoids ❑Worry/Over-thinking

Spleen, Stomach, Large Intestine, Small Intestine function:
❑Loose stools ❑Constipated ❑Incomplete stools ❑Diarrhea
❑Blood in stools ❑Mucous in stools ❑Undigested food in stools

Dampness trapped in the body:
❑General sensation of heaviness ❑Mental fogginess ❑Swollen hands
❑Swollen feet ❑Swollen joints ❑Chest congestion ❑Nausea

Stomach function:
❑Burning sensation after eating ❑Large appetite ❑Bad breath
❑Mouth (canker) sores ❑Bleeding, swollen or painful gums
❑Heartburn ❑Acid regurgitation ❑Ulcer (diagnosed) ❑Belching
❑Hiccoughs ❑Stomach pain ❑Vomiting

Liver, Gall Bladder function:
❑Alternating diarrhea and constipation ❑Chest pain
❑Tight sensation in the chest ❑Bitter taste in the mouth
❑Anger easily ❑Frustration ❑Depression ❑Irritability
❑Frequently unable to adapt to stress (What causes the stress? _____)
❑Skin rashes ❑Headache at the top of the head ❑Numbness
❑Tingling sensation ❑Muscle spasms ❑Muscle twitching ❑Muscle cramping
❑Seizures ❑Convulsions ❑Lump in the throat ❑Neck tension
❑Limited Range-of-Motion, Neck ❑Shoulder tension
❑Limited Range-of-Motion, Shoulder ❑Drink alcohol
❑Recreational drugs (Which? _____, How much per week? _____)
❑High-pitched ringing in the ears ❑Gall stones (history or current)

Eyes (Liver function):
❑Itchy ❑Bloodshot ❑Burning ❑Dry
❑Watery ❑Gritty ❑Blurry vision ❑Decreased night vision
❑Near-sighted ❑Far-sighted

Kidney, Urinary Bladder function:
❑Frequent cavities ❑Easily broken bones ❑Sore knees
❑Weak knees ❑Cold sensation in the knees ❑Low back pain
❑Memory problems ❑Excessive hair loss ❑Low-pitched ringing in the ears
❑Kidney stones ❑Bladder infections ❑Wake during the night twice or more to urinate
❑Lack of bladder control ❑Fear ❑Easily startled

Urination:
❑Normal color ❑Dark yellow ❑Clear ❑Reddish
❑Cloudy ❑Scanty ❑Profuse ❑Strong odor
❑Burning ❑Painful ❑Discharge ❑Difficult
❑Urgent ❑Frequent

Libido:
❑Normal ❑High ❑Low

☯☯☯

***Women only*:**

Monthly menstrual cycle? ❑Y ❑N Currently Pregnant? ❑Y ❑N ❑Possibly
Number of pregnancies:______ Number of miscarriages:______
Number of abortions: ______ Number of children:______
Age of first menstrual cycle:______ Age of menopause (if applicable):______
Average number of days of flow:______ ❑Form of Contraception ______________________________
Average number of days of entire cycle (from first day of flow to next first day of flow):__________
❑Bleeding between periods ❑Hormone Replacement
❑Abnormal Pap Smear ❑Vaginal Infections
❑Endometriosis ❑Uterine Fibroids

Do you experience any of the following pre-menstrual syndromes?

❑Nausea	❑Vomiting	❑Water retention	❑Breast swelling/tenderness
❑Food cravings	❑Headaches	❑Migraines	❑Hot at night
❑Depression	❑Irritability	❑Anxiety	❑Constipation

Emotions:____
❑Dull pain, where?____________________ ❑Sharp pain, where?________________________

Do you experience any of the following with your menstrual flow?

❑Cramps	❑Clots	❑Heavy blood flow	❑Minimal blood flow
❑Tiredness	❑Loss of Appetite	❑Diarrhea	❑Headaches
❑Dizziness	❑Depression		

☯☯☯

Men only:

❑Swollen testes	❑Testicular pain	❑Impotence	❑Premature ejaculation
❑Prostate problems		❑Other__________________________________	

☯☯☯

For everyone:

I accept my responsibility to provide a 24-hour appointment cancellation notice. Your missed appointment fee of $65.00 will be donated to Heifer International.

Patient Signature:____ Date ______________________

Acupuncturist Signature:____ Date ______________________

SOCIAL HISTORY & LIFESTYLE

It is important that we understand your general lifestyle as it often has a significant impact on your overall health. Please check mark the box which **most closely** describes your general lifestyle for each question.

1. Smoking: (For cigars, pipes, or chewing tobacco estimate the amount of tobacco used per day.)

☐	☐	☐	☐	☐
I do not smoke.	I smoke 1/4 pack or less per day.	I smoke 1/2 pack per day.	I smoke 3/4 pack per day.	I smoke 1 pack per day.

2. Alcohol: On average how many alcoholic drinks do you consume per week?
   (one drink = 12 oz. of beer, 4 oz. of wine, 1 wine cooler, 1 cocktail, or 1 shot of hard liquor)

☐	☐	☐	☐	☐	☐
None	1 drink/week	2-7 drinks/week	8-14 drinks/weeks	15-21 drinks/week	+22 drinks/week

3. Caffeine: On average how many caffeinated drinks do you consume per day? (soda, coffee, tea)

☐	☐	☐	☐	☐	☐
None	1 drink/day	2 drinks/day	3 drinks/day	4 drinks/day	5+ drinks/day

4. Exercise: For this questions, exercise means at least 30 minutes of activity.

☐	☐	☐	☐	☐
I exercise 3-5 Days/week	I exercise 2 Days/week	I exercise 1 Days/week	I exercise 1 Days/month	I am not exercising

5. Diet: Fruits and Vegetables are abbreviated as F&V.

☐	☐	☐	☐	☐
I eat 3 or more servings of F&V per day	I eat 2 servings of F&V per day	I eat 1 serving of F&V per day	I eat 1-4 servings of F&V per week	I eat NO servings of F&V per week

6. Sleep: How many hours of undisturbed sleep to you get each night?

☐	☐	☐	☐	☐
Less than 6 hours	6 hours	7 hours	8 hours	More than 8 hours

7. Stress: Rate the level of stress in your life on a daily basis 0 = NO STRESS and 10 = HIGH STRESS.

0 1 2 3 4 5 6 7 8 9 10

8. Health: How would you rate your overall health.

☐	☐	☐	☐	☐
Excellent	Very Good	Good	Fair	Poor

Patient Signature _____ Date _____