Name_____ Date_____

Address_____City _____State_____Zip_____

Home phone _____ Work phone _____ Cell_____

Email _____

Have you had acupuncture before? ☐Yes ☐ No

Height _____ Weight _____ Age _____ Sex: ☐ M ☐ F ☐other Date of birth_____

In emergency notify (name): _____ Emergency phone number_____

Marital Status: ☐Single ☐Married ☐Domestic Partner ☐Divorced ☐ Widowed ☐ Separated

Primary Care Doctor: _____

Last seen:_____

How did you hear about us: ☐Ad in _____ ☐ Article in _____

☐ Talk at _____ ☐ Brochure ☐ Business Card ☐ Website ☐ Referred by_____

The information on pages 1 - 4 is true to the best of my knowledge.
I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service.
I also understand and accept that I am expected to notify Meade Danielle Mueller 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Signed: _____
Date: _____
Parent / Guardian (if applicable)
_____

Confidential Patient Information Sheet

Medical History

Reason for your visit here today:

:_____

_____

_____

Are you being treated for this condition by anyone else: ☐ Yes ☐ No

If Yes, who? _____

Phone number:_____

Has this condition been diagnosed by a MD?

☐ Yes, Diagnosis: _____ ☐ No

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not much ☐ Not at all

How does this condition affect you?

_____

_____

How long have you had this condition?_____

Known or suspected allergies:_____

Childhood diseases you have had:

☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rheumatic Fever ☐ Diphtheria ☐ Scarlet Fever ☐Other

Accidents / Hospitalizations / Surgeries in the past 10 years:

Type Reason Date

_____

_____

_____

Your general health as a child: ☐ Excellent ☐ Good ☐ Average ☐Poor

Father Overall Health ☐ Good ☐ Poor Age (at death)_____ Cause of death_____

Mother Overall Health ☐ Good ☐Poor Age (at death)_____ Cause of death_____

Health Inventory

Cardiovascular Conditions:

- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:

- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety
- ☐ Alzheimer's
- ☐ Dementia

Energy & Immunity:

- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Respiratory:

- ☐ Pneumonia
- ☐ Asthma
- ☐ Common Colds
- ☐ Emphysema/COPD
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Musculo-Skeletal:

- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

Head, Eye, Ear, Nose & Throat:

- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems
- ☐ Hay Fever

Genito-Urinary Tract:

- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Incontinence

Neurological:

- ☐ Vertigo / Dizziness
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy
- ☐ Dyslexia

Gastrointestinal:

- ☐ Stomach Ulcers
- ☐ IBS
- ☐ Nausea / Vomiting
- ☐ Abdominal Pain
- ☐ Passing Gas
- ☐ Heart Burn
- ☐ Diverticulitis/losis
- ☐ SIBO
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea

Endocrine:

- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

Other:

- ☐ Cancer Type:_____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Cold Hand / Feet
- ☐ Hemophilia
- ☐ Thin / Graying hair

Liver Conditions:

- ☐ Hepatitis A, B, C

Men Only

☐ Impotence
☐ Vasectomy
Date: _____
☐ Prostate problems
☐ Testicular Pain / Redness / Swelling
☐ Low libido
☐ Excessive libido
☐ Seminal emissions
☐ Painful Intercourse

Women Only

☐ Yes I am pregnant
☐ Maybe I am pregnant
☐ No I am not pregnant
Method of Birth Control:
_____
Age at first period:
_____
Date of last menses:
_____
Age at menopause:
_____
Typical length of cycle (days):
_____
Number of:
Pregnancies: _____
Births: _____
Miscarriages: _____
Hysterectomy: ☐Yes☐ No Date:
_____
Check all that apply

☐ Clotting
☐ Painful Periods
☐ Heavy Flow
☐ Scanty Flow
☐ Bleeding Between Cycles
☐ Irregular Cycles
☐ Vaginal Discharge
☐ Breast Lumps / Tenderness
☐ Nipple Discharge
☐ Infertility
☐ Menopausal Symptoms
☐ Premenstrual Problems

Please list all prescription and over the counter medications you are currently taking:

Drug Name Reason for taking Dose Frequency

_____
_____
_____
_____
_____
_____
_____

Please list all supplements and herbs you are currently taking:

Supplement Reason for taking Potency Frequency

_____
_____
_____
_____

Daily amount used within the past 2 months

Tobacco: ☐ Yes ☐ No Amount: _____
Alcohol: ☐ Yes ☐ No Amount:
Coffee: ☐ Yes ☐ No Amount: _____
Recreational Drugs: ☐ Yes ☐ No Amount:
Do you feel you are at or near your ideal weight? ☐ Yes ☐ No
Do you feel you have enough energy? ☐ Yes ☐ No
Are you vegetarian or vegan? ☐ Yes ☐ No
Best time of day: _____
Worst time of day:_____
Favorite Season: _____
Hours of sleep / night:_____
Do you feel rested after a nights sleep? _____
Do you remember your dreams?_____
Food cravings:_____
What kind of physical exercise to you do regularly?
_____
Please feel free to express any concerns or thoughts you feel may be relevant to your health below:

_____
_____
_____
_____
_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

X_____