Into the Light
Acupuncture and Holistic Medicine
Lauren Pitasch LA.c MSOM

Acupuncture and Herbal Medicine Patient Information Form

Today's Date _____

General Information

Name _____ Please address me as _____ Gender _____

Address _____ City _____ State _____ Zip _____

Phone (W) _____ (H) _____ (Cell) _____

Email Address _____ Age _____ DOB _____

Occupation _____ Employer _____ Hrs/Wk _____

Marital Status _____ Referred By _____

Emergency Contact _____ Phone _____

Have you ever had acupuncture before? _____ Have you had Chinese herbal medicine before? _____

Primary Physician _____ Other Physician (1) _____

Other Physician (2)_____ Other Physician (3)_____

Chiropractor _____ Massage Therapist _____

Other

How did you hear about us? _____

How familiar are you with the concepts of oriental medicine (e.g. Qi, Meridians, Yin, Yang)?

[ ] Very familiar [ ] Somewhat familiar [ ] Not very familiar [ ] Not at all familiar

Health History

What treatment(s) have you already received for this condition?

[ ] Medications [ ] Surgery [ ] Chiropractic Services [ ] Physical Therapy [ ] None [ ] Other _____

Name of other doctor(s) who have treated this condition _____

Date of last: Physical Exam_____ Spinal X-Ray_____ Urine Test_____

Spinal Exam_____ Chest X-Ray_____ Dental X-Ray_____

Blood Test_____ MRI/CT Scan/Bone Scan_____

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Please mark the proper box to indicate if you have *ever* had the following. Circle current conditions.

General
[ ] Anemia
[ ] Appendicitis
[ ] Bleeding Disorders
[ ] Chicken Pox
[ ] Chills and/or Sweats
[ ] Diabetes
[ ] Difficulty Sleeping
[ ] Dizziness
[ ] Drug Use (recreational)
What type? _____
[ ] Epilepsy
[ ] Fainting
[ ] Fatigue / Tiredness
[ ] Fever
[ ] Gonorrhea
[ ] Gout
[ ] Hair Loss
[ ] Headache
[ ] Hepatitis
[ ] Hernia
[ ] Herpes
[ ] Kidney Disease
[ ] Liver Disease
[ ] Measles
[ ] Migraine Headache
[ ] Mumps
[ ] Numbness
[ ] Parkinson's Disease
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Stroke
[ ] Thyroid Problem
[ ] Tumors or Growths
[ ] Weight Loss
[ ] Weight Gain

Immune Health
[ ] AIDS/HIV
[ ] Allergy Shots
[ ] Cancer
[ ] Mononucleosis
[ ] Pneumonia
[ ] Polio
[ ] Venereal Disease
[ ] Whooping Cough

Muscles and Joints
[ ] Arthritis
[ ] Fractures
[ ] Herniated Disk
[ ] Multiple Sclerosis
[ ] Osteoporosis
[ ] Rheumatoid Arthritis

Respiratory
[ ] Asthma
[ ] Bronchitis
[ ] Emphysema
[ ] Smoking
How much?
_____ packs/day
[ ] Tuberculosis

Dental Health
[ ] Dental Problems
[ ] Dental Fillings
[ ] TMJ Problems

Emotional Health
[ ] Alcoholism
[ ] Anorexia / Bulimia
[ ] Chemical Dependency
[ ] Depression
[ ] Forgetfulness
[ ] Nervousness
[ ] Psychiatric Care
[ ] Suicide Attempt

Genito-Urinary
[ ] Blood in Urine
[ ] Frequent Urination
[ ] Kidney Stone
[ ] Lack of Bladder Control
[ ] Painful Urination

Gastrointestinal
[ ] Appetite Poor
[ ] Bloating and/or Gas
[ ] Bowel Changes
[ ] Constipation
[ ] Diarrhea
[ ] Excessive Hunger
[ ] Excessive Thirst
[ ] Hemorrhoids
[ ] Indigestion
[ ] Nausea
[ ] Rectal Bleeding
[ ] Stomach Pain
[ ] Vomiting
[ ] Vomiting Blood

Cardiovascular
[ ] Chest Pain
[ ] Heart Disease
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Irregular Heart Beat
[ ] Low Blood Pressure
[ ] Pacemaker
[ ] Poor Circulation
[ ] Rapid Heart Rate
[ ] Ulcers
[ ] Varicose Veins

Eye, Ear, Nose & Throat
[ ] Bleeding Gums
[ ] Blurred Vision
[ ] Crossed Eyes
[ ] Difficulty Swallowing
[ ] Double Vision
[ ] Earache
[ ] Ear Discharge
[ ] Glaucoma
[ ] Goiter
[ ] Hay Fever
[ ] Hoarseness
[ ] Loss of Hearing
[ ] Nosebleeds
[ ] Persistent Cough
[ ] Ringing in Ears
[ ] Sinus Problems
[ ] Tonsillitis
[ ] Vision – Flashes
[ ] Vision – Halos

Skin
[ ] Bruise Easily
[ ] Hives or Rashes
[ ] Itching
[ ] Change in Moles
[ ] Scars
[ ] Sore that won't heal

Men Only
[ ] Breast Lump
[ ] Erection Difficulties
[ ] Lump in Testicles
[ ] Low Libido
[ ] Penis Discharge
[ ] Prostate Problem
[ ] Sore on Penis
[ ] Vasectomy

Women Only
[ ] Abnormal Pap-Smear
[ ] Birth Control Pills
[ ] Birth Control Device
_____
[ ] Bleeding Between Periods
[ ] Breast Lump
[ ] Extreme Menstrual Pain
[ ] Hot Flashes
[ ] Infertility
[ ] Low Libido
[ ] Miscarriage
[ ] Nipple Discharge
[ ] Painful Intercourse
[ ] PMS
[ ] Uterine Cysts
[ ] Vaginal Discharge
[ ] Vaginal Infections
(1) Date of last menstrual period_____
Date of last pap-smear
_____
(2) Have you ever had an abortion? [ ] Yes [ ] No
(3) Number of Children
_____

[ ] Other _____
_____
_____
_____
_____
_____
_____
_____
_____

Please list and explain any injuries or surgeries you have had:

[ ] Falls _____ Date _____
[ ] Head Injuries _____ Date _____
[ ] Dislocations _____ Date _____
[ ] Surgeries _____ Date _____
[ ] Broken Bones _____ Date _____
[ ] Other _____ Date _____

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NECK, BACK AND EXTREMETIES

Please mark the proper box to indicate if you have *ever* had the following. Circle current conditions.

Neck
[ ] Pain in Neck
[ ] Neck Stiffness
[ ] Neck Weakness
[ ] Pinched Nerve in Neck
[ ] Neck Feels Out of Place
[ ] Muscle Spasms
[ ] Grinding/Popping Sounds

Shoulders
[ ] Pain in Shoulder Joint
[ ] Right [ ] Left
[ ] Pain across Shoulders
[ ] Can't Raise Arm
[ ] Right [ ] Left
[ ] Above Shoulder Level
[ ] Over Head
[ ] Tension in Shoulders
[ ] Shoulder Pinched Nerve
[ ] Right [ ] Left

Mid-Back
[ ] Mid-Back Pain
[ ] Mid-Back Stiffness
[ ] Pain between Shoulders
[ ] Pain from Front to Back
[ ] Muscle Spasms in Back

Arms & Hands

[ ] Pain in Upper Arms	[ ] R	[ ] L
[ ] Pain in Elbow	[ ] R	[ ] L
[ ] Pain in Forearm	[ ] R	[ ] L
[ ] Pain in Hand	[ ] R	[ ] L
[ ] Pain in Fingers	[ ] R	[ ] L
[ ] Pins & Needles Arm	[ ] R	[ ] L
[ ] Pins & Needles Fingers	[ ] R	[ ] L
[ ] Numbness in Arm	[ ] R	[ ] L
[ ] Numbness in Fingers	[ ] R	[ ] L
[ ] Weakness of Arm	[ ] R	[ ] L
[ ] Weakness of Hand	[ ] R	[ ] L
[ ] Hands Cold	[ ] R	[ ] L

Low Back
[ ] Low Back Pain
[ ] Low Back Stiffness
[ ] Low Back Weakness
[ ] Pinched Nerve
[ ] Feels out of Place
[ ] Muscle Spasms

Hips, Legs & Feet

[ ] Pain in Buttocks	[ ] R	[ ] L
[ ] Pain in Hip Joint	[ ] R	[ ] L
[ ] Pain Down Leg	[ ] R	[ ] L
[ ] Pain in Knee	[ ] R	[ ] L
[ ] Pain in Ankle	[ ] R	[ ] L
[ ] Pain in Foot	[ ] R	[ ] L
[ ] Weakness of Leg	[ ] R	[ ] L
[ ] Weakness of Knee	[ ] R	[ ] L
[ ] Leg Cramps	[ ] R	[ ] L

FAMILY HEALTH HISTORY

Is your father living? [ ] Yes [ ] No
If yes, how old is he? _____
Please list any medical problems:
_____
_____
If no, what was the cause of his death?
_____
Age at death: _____

Is your mother living? [ ] Yes [ ] No
If yes, how old is she? _____
Please list any medical problems:
_____
_____
If no, what was the cause of her death?
_____
Age at death: _____

Please check below if the following conditions occur within your family history (Parents, Grandparents, Siblings, Aunts, and Uncles):

	Relationship to you:
[ ] Heart Disease (heart attacks under 55 years of age)	_____
[ ] High Blood Pressure	_____
[ ] Diabetes	_____
[ ] Stroke	_____
[ ] Cancer	_____

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