Tao of Women
Acupuncture Clinic
Annie Vedeler, L.Ac, Dipl. OM
www.taoofwomen.com
4803597389

Confidential Patient History

Patient Information

Name ______________________________ Date ______________

Address ______________________________ City ______________ State _______

Zip ___________ Home phone ______________ Work phone ______________ Cell ______________

Email ______________________________ Have you had acupuncture before? ☐ Yes ☐ No

Height ________ Weight ________ Age ______ Sex: ☐ Male ☐ Female Other ______ Date of birth ________

Occupation ______________________________ Employer ______________________________

In emergency notify (name): ______________________ Emergency phone number: ______________

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

Number of children: __________ Ages of children: ______________ Number who live with you: ________

Others living with you: ____

Primary Care Doctor ______________________________ Last seen: ______________

How did you hear about the Tao of Women Acupuncture Clinic ?

☐ Brochure ☐ Business Card ☐ Referred by ______________________ ☐ Other ______________

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? ____

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly

If Yes, please identify: ☐ HIV + ☐ Hepatitis B ☐ Hepatitis C ☐ Flu / Cold ☐ Streptococcus

☐ Mononucleosis ☐ Tuberculosis ☐ Other: ____

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:

Reason Date / Year(s)

____

____

____

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

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Health Inventory

Cardiovascular Conditions:	**Emotional / Mental**:	**Energy & Immunity**:	**Respiratory**:
☐ Heart Disease	☐ Clinical Depression	☐ Chronic Fatigue Syndrome	☐ Pneumonia
☐ Pacemaker	☐ Mild Depression	☐ General Fatigue	☐ Asthma
☐ High Blood Pressure	☐ ADD or ADHD	☐ Slow Wound Healing	☐ Frequent Common Colds
☐ Low Blood Pressure	☐ Schizophrenia	☐ Easy Bruising	☐ Difficulty Breathing
☐ Chest Pain	☐ Mood Swings	☐ Chronic Infections	☐ Emphysema
☐ Palpitations	☐ Panic Attacks	☐ Frequent Allergies	☐ Persistent Cough
☐ Stroke	☐ Nervousness		☐ Pleurisy
☐ Varicose Veins	☐ Anxiety		☐ Tuberculosis
☐ Edema	☐ Alzheimer's		☐ Shortness of Breath
	☐ Dementia		
Musculo-Skeletal:	**Head, Eye, Ear, Nose & Throat**:	**Genito-Urinary Tract**:	**Gastrointestinal**:
☐ Neck / Shoulder Pain	☐ Impaired Vision	☐ Kidney Disease	☐ Stomach Ulcers
☐ Muscle Spasms / Cramps	☐ Eye Pain/Strain	☐ Kidney/Bladder Stones	☐ Changes in Appetite
☐ Arm Pain	☐ Glaucoma	☐ Painful Urination	☐ Nausea / Vomiting
☐ Upper Back Pain	☐ Glasses / Contacts	☐ Dribbling Urination	☐ Epigastric / Abdominal Pain
☐ Mid Back Pain	☐ Tearing / Dryness	☐ Urinary Tract Infection	☐ Passing Gas
☐ Low Back Pain	☐ Impaired Hearing	☐ Frequent Urination	☐ Heart Burn
☐ Leg Pain	☐ Ear Ringing	☐ Blood in Urine	☐ Belching
☐ Osteoporosis	☐ Earaches	☐ Discharge	☐ Gall Bladder Disease
☐ Arthritis____________	☐ Ear Infections	☐ Incontinence	☐ Gall Bladder Stones
☐ Joint Pain	☐ Headaches		☐ Hemorrhoids
	☐ Sinus Problems	**Neurological**:	☐ Constipation
	☐ Nose Bleeds	☐ Vertigo / Dizziness	☐ Diarrhea
	☐ Teeth Grinding	☐ Paralysis	
	☐ Frequent Sore Throats	☐ Numbness / Tingling	
	☐ TMJ / Jaw Problems	☐ Loss of Balance	
	☐ Hay Fever	☐ Seizures / Epilepsy	
		☐ Dyslexia	
Endocrine:	**Other**:	**Liver Conditions:**	**Men Only:**
☐ Hypothyroid	☐ Cancer Type:_______________	☐ Hepatitis A	☐ Impotence
☐ Hypoglycemia	☐ Fibromyalgia	☐ Hepatitis B	☐ Vasectomy Date: ______________
☐ Hyperthyroid	☐ Lupus	☐ Hepatitis C	☐ BPH (Prostate)
☐ Diabetes Type I	☐ Candida (Yeast)	☐ Cirrhosis	☐ Testicular Pain / Redness / Swelling
☐ Diabetes Type II	☐ Anemia	☐ Fatty Liver	☐ Low libido
☐ Diabetes Inispidus	☐ Rashes		☐ Excessive libido
☐ Night Sweats	☐ Eczema / Hives		☐ Painful Intercourse
☐ Sweating w/o exertion	☐ Cold Hands / Feet		☐ Seminal emissions
☐ Unusual Sweating	☐ Hemophilia		
☐ Feeling Hot or Cold	☐ Thin / Graying hair		

Women Only: Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe Birth Control method:______________

Age at first period: _____ Date of last menses: ___________ Age at menopause: _____

Typical length of menses (days): ________ Typical length of cycle (from 1st day to 1st day of menses): ________

Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: ______

Hysterectomy: ☐ Yes ☐ No Date: ______________ *Check all that apply:* ☐ Dark color ☐ Pale, watery

☐ Low libido ☐ Excessive libido ☐ Painful Intercourse ☐ Clotting ☐ Painful Periods

☐ Heavy Flow ☐ Scanty Flow ☐ Bleeding Between Cycles ☐ Irregular Cycles ☐ Vaginal Discharge ☐ Breast Lumps / Tenderness ☐ Nipple Discharge ☐ Infertility ☐ Menopausal Symptoms ☐ Premenstrual Irritability

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Medications

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

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements, vitamins and herbs you are currently taking:

Supplement	Reason for taking	Dosage	Frequency

Lifestyle

(Daily amount used within the past 3 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?_______________

Typical day's meals:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks / Other: ____

Food cravings: ____

Religion or other spiritual practice: ____

Hobbies or other recreation: ____

What kind of physical exercise do you do regularly? ________________________________

Hours of television watched per week? _____ % of microwave use?_______Hours of work per week? _________

Highest level of education completed? ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other

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How would you rate your current stress level? ☐ Extreme ☐ Very High ☐ High ☐ Moderate ☐ Low

Emotions / Relationships

Number of biological Brothers: ________ Sisters: ________ Were you adopted? ☐ Yes ☐ No

Your place in the birth sequence #: ______________

Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What would you characterize as your predominate emotion right now? ☐ Anxiety / Worry ☐ Anger ☐ Grief ☐ Fear / Dread ☐ Depression ☐ Melancholy ☐ Happiness ☐ Contentment ☐ Joy ☐ Numbness / Apathy ☐ Other:____

Do you enjoy your work? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? ____

Do you love where you live? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Why or why not? ____

Do you feel you have a higher purpose for your life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

Do you feel safe in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Do you feel nurtured in your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you happy with your current significant relationship(s)? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Are you satisfied with your sex life? ☐ Yes ☐ Usually ☐ Sometimes ☐ Rarely ☐ No

If you were guaranteed of success and money and time were not obstacles, what would you like to do with your life?

____

Please feel free to express any concerns or thoughts you feel may be relevant to your health below:
Use the diagram if desired.

____
____
____
____
____
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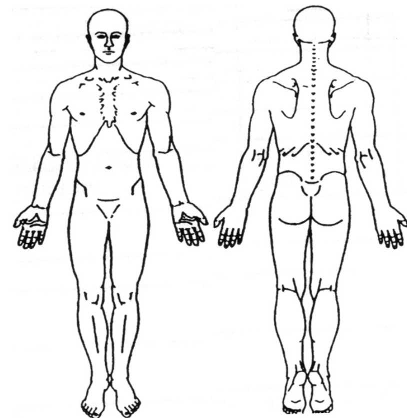
____



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The above information 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 Annie Vedeler, L.Ac 24 hours prior to any cancellations and that if I do not I may be charged for the appointment.

X Signed: ____ Date: ________________

Parent / Guardian (if applicable) ____