ACUPUNCTURE NEW CLIENT The Still Point is a unique wellness spa and there is no one-size-fits-all service here. We want to learn about you and how our team of healing practitioners can meet your wellness needs.

IDENTIFICATION:

Name: ____ Sex: M ____ F____ Date: _______________

Address: ___________________________________ City: __________________ State: _______ Zip: ________

Telephone: Home: ____________________ Work: ____________________ Cell: ______________________

Date of Birth: ____________________ Age: ______ Email: ____

Single: ______ Married: ______ Partnered: ______ Separated/Divorced: ______ Widowed: ______

Education: ___________________________________ Occupation: _________________________________

Emergency Contact Name and Relation: _______________________ Phone: ___________________________

Name of Physician (No contact will be made with the physician without your permission): _________________________________

Address/Phone of Physician: ____

Date of Last Physician Appointment: _____________________ Purpose: ________________________________

Date of Last Gynecology Exam (women only): ____

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes/No

How did you hear about us? ___ Facebook ___ Yelp ___ Search Engine ___ Awesome Person Other: _____________

Chief Concern/Complaint:____

FAMILY HISTORY Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	SELF	MOTHER	FATHER	SIBLING	SPOUSE	CHILDREN
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease/stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (age)	N/A					

PERSONAL LIFESTYLE HABITS: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs per day) _____ Coffee/Tea (cups per day) _____ Alcohol (drinks per week) ______

Exercise Y / N How often ______________________

MEDICAL: If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please write the most recent ones below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

MEDICINES: (Check here ____ if more information is on reverse side of this sheet)

What prescription drugs are you currently taking, include dosage: | For what condition?

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

What over-the-counter medications, herbs, or supplements are you currently taking, include dosage: | For what condition?

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS:
If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

GENERAL
__ Insomnia
__ Dreams/ nightmares
__ Fatigue
__ Poor memory
__ Strongly like cold drinks
__ Strongly like hot drinks
__ Recent weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever
__ Bad breath
__ Other (describe)
____

HEAD AND NECK
__ Headaches
__ Migraines

___ Stiff neck
___ Dizziness
___ Fainting
___ Swollen glands
___ Other (describe)
____

EARS
___ Ringing
___ Hearing loss
___ Hearing aids
___ Infections
___ Earache
___ Vertigo
___ Other (describe)
____

EYES
___ Glasses/ contact lenses
___ Blurred vision
___ Poor night vision
___ Spots or floaters
___ Eye inflammation
___ Double vision
___ Glaucoma
___ Cataracts
___ “Lazy” eye
___ Other (describe)
____

NOSE, THROAT, AND MOUTH
___ Sinus infection
___ Hay fever/ allergies
___ Frequent sore throat
___ Difficulty swallowing
___ Mouth & tongue ulcers
___ Frequent colds
___ Nosebleed
___ Dry nose
___ Nasal congestion
___ Loss of voice
___ Thirst
___ Excessive phlegm
___ TMJ
___ Facial pain
___ Gum problems
___ Dry mouth
___ Other (describe)
____

SKIN
___ Hives
___ Rashes
___ Eczema/ psoriasis
___ Night sweating
___ Excess sweating
___ Dry skin
___ Easily bruised
___ Changes in moles, lumps
___ Itching
___ Other (describe)
____

URINARY
___ Pain on urination
___ Frequent urination
___ Urgent urination
___ Blood in urine
___ Incontinence
___ Incomplete urination
___ Bedwetting
___ Wake to urinate
___ Kidney (specify)
____
____
___ Other (describe)
____

RESPIRATORY
___ Difficulty breathing
___ Difficulty breathing when reclining
___ Wheezing
___ Asthma
___ Chronic cough
___ Wet cough
___ Dry cough
___ Coughing up phlegm
___ Coughing up blood
___ Shortness of breath
___ Tight chest
___ Pneumonia
___ Other (describe)
____

CARDIOVASCULAR
___ High blood pressure
___ Low blood pressure
___ Chest pain or tightness
___ Palpitation
___ Rapid heart beat
___ Irregular heart beat
___ Poor circulation
___ Swollen ankles
___ Phlebitis
___ Anemia
___ History of heart disease
___ Heart murmur
___ Other (describe)
____

MUSCULOSKELETAL
___ Joint pain/swelling
___ Sore muscles
___ Weak muscles
___ Difficulty walking
___ Pain (describe)
____
____
___ Limited range of motion
___ Other (describe)
____

MENTAL/EMOTIONAL
__ Depression
__ Mood swings
__ Irritability
__ Difficulty relaxing
__ Loneliness
__ Sensitive
__ Shyness
__ Frequent crying
__ Worries frequently
__ Compulsive behaviors
__ Difficulty focusing
__ Hopeless outlook
__ Suicidal thoughts
__ Lose temper
__ Frustration
__ Other (describe)
____

NEUROLOGICAL
__ Seizures
__ Tremors
__ Numbness or tingling
__ Pain (describe)
__ Paralysis
__ Poor coordination
__ Other (describe)
____

GASTROINTESTINAL
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid regurgitation
__ Bloating
__ Laxative use
__ Bloody stool
__ Other (describe)
____

INFECTION SCREENING (Circle self and/or partner)
__ HIV risks: self or partner
__ TB: self or household
__ Hepatitis risk: self or partner
__ History of sexually transmitted disease: self or partner (specify)
____
__ Other (describe)
____

GYNECOLOGY (Women Only)
__ Currently pregnant
__ # of Pregnancies
__ # of Live births
__ # of Miscarriages
__ # of Abortions
__ Menopause
__ Irregular periods
__ Menstrual cramps
__ Excessive blood flow
__ Menstrual blood clots
__ Breast tenderness
__ Abnormal pap smear
__ Vaginal infections
__ Vaginal pain/itching
__ Uterine fibroids
__ Endometriosis
__ Breast lumps, cysts
__ Increased libido
__ Decreased libido
__ Other (describe)
____

MALE GENITALS
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain/itching of genitalia
__ Lumps in testicles
__ Increased libido
__ Decreased libido
__ Other (describe)
____

Trauma (list)
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________!
________________________________ ________________________________ ________________________________

OTHER INFORMATION:
____!
____

____ ________________________

Signature **Date**