



Alpenglow Acupuncture, LLC

As a new patient, and to help us understand any health issues you may have, please fill out the information below to the best of your ability. All information is confidential.

Patient Name: _____ DOB: _____ Intake Date: _____

Chief Complaint: _____

Patient Medical History *Please check if you have ever had any of the following. Leave blank if uncertain.*

<input type="checkbox"/> Measles	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Arthritis	<input type="checkbox"/> AIDS or HIV
<input type="checkbox"/> Mumps	<input type="checkbox"/> IBS / Diverticulitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Infectious Mono / Epstein Barr Virus
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Hives or Eczema	<input type="checkbox"/> Hepatitis A B C
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> STD
<input type="checkbox"/> Smallpox	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood/Plasma Transfusion
<input type="checkbox"/> Polio	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Bleeding Tendency
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Back Trouble	<input type="checkbox"/> Bruising
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Other Diseases (Please list)
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Head Injury	_____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Fibromyalgia	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> High / Low Blood Pressure	<input type="checkbox"/> Chronic Fatigue	
<input type="checkbox"/> Respiratory Disease			Date of Last Physical Exam: _____

Previous Hospitalizations / Surgeries / Serious Illnesses / Traumatic Events

Date

_____	_____
_____	_____

Medications *(include herbs, supplements and over the counter items)*

Allergies: _____

Patient Social History

Marital Status:	Alcohol use:	Caffeine use:	Smoking:	Exercise:	Sleep Habits:	Exposure to:
<input type="checkbox"/> Single	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Rare	<input type="checkbox"/> 6-8 hours	<input type="checkbox"/> Fumes
<input type="checkbox"/> Married	<input type="checkbox"/> Rarely	<input type="checkbox"/> Rarely	<input type="checkbox"/> Previously, but quit:	<input type="checkbox"/> Occasional	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Dust
<input type="checkbox"/> Living w/partner	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	_____	<input type="checkbox"/> Regularly	<input type="checkbox"/> Wake up too early	<input type="checkbox"/> Solvents
<input type="checkbox"/> Separated	<input type="checkbox"/> Daily	<input type="checkbox"/> Daily	<input type="checkbox"/> Currently smoking _____ packs/day	<input type="checkbox"/> Daily	<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Airborne particles
<input type="checkbox"/> Divorced	Amount/day: _____	Amount/day: _____		Type of exercise: _____	<input type="checkbox"/> Dreamer	<input type="checkbox"/> Noise
<input type="checkbox"/> Widow						<input type="checkbox"/> Vaccinations

Drug use: Never Type/frequency _____

Special Diet: Yes if so, type: _____

Family Medical History

	Age	Diseases	Date deceased, cause of death
Spouse	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Who do you see for Medical Doctors? _____



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Patient Name _____

Date _____

Constitutional Symptoms

- General health the past year
 - Good Poor
- Recent weight change _____
- Fever
- Fatigue / Poor Energy
- Sleep problems / snoring

Eyes

- Eye disease or injury
- Wear glasses or contacts
- Eye Surgery _____
- Blurred or double vision

Ear/Nose/Mouth/Throat

- Hearing loss or ringing of ears
- Ear pain or drainage
- Ear Infections
- Sinus Infections / Problems
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Sore throat or voice change
- Swollen glands in neck

Cardiovascular

- Last cholesterol screen
 - Date _____ Total _____
 - LDL _____ HDL _____
 - Triglycerides _____
- Heart trouble / attack
- Chest pain / angina
- Heart medications
- Blood thinner medications
- Heart Murmur
- High blood pressure
- Shortness of breath walking
- Pain in legs with walking
- Shortness of breath at rest
- Swelling of feet or ankles
- Varicose veins
- Cold Extremities

Respiratory

- Cough
- Shortness of breath
- Wheezing / Asthma
- Inhaler use
- Coughing up blood
- Tobacco use or exposure

Gastrointestinal

- Colon cancer screen
 - Date: _____
- Appetite:
 - Good
 - Poor
 - Excessive
- Change in appetite recently
- Nausea or vomiting
- Heartburn / Reflux
- Abdominal Pain
- Bloating
- Fatigue after eating
- Bowel movements:
 - #/day _____ Easy Hard
- Skip days of moving bowels
- Constipation
- Loose stool or diarrhea
- Painful bowel movements
- Change in bowel habits
- Rectal bleeding or blood in stool

Musculoskeletal / Pain

- Muscle aches or cramping
- Joint pain or stiffness
- Joint swelling
- Low Back Pain
- Neck Pain
- Difficulty Walking or Standing
- Osteoporosis - Bone Scan _____
- History of Injuries and Accidents
- Date: _____
- Date: _____

Neurological / Psychological

- Headaches:
 - Daily
 - Weekly
 - Rarely
- Migraines
- Sinus headaches
- Tension headaches
- Dizziness or Light headed
- Convulsions or seizures
- Tremors
- Paralysis
- Numbness or tingling
- Depression
- Anxiety / Nervousness
- Memory Loss / Confusion
- Abuse Survivor

Genitourinary

- Frequent urination
- Nighttime urination
- Urgency / burning / painful urination
- Blood in urine
- Change in urine stream
- Incontinence or dribbling
- Kidney stones
- Sexual difficulty
- Male: Testicle Pain
- Male: Last PSA _____
Prostate Check _____

Female:

- Last Menstrual Period _____
- Menses LMP _____
 - Regular
 - Irregular
 - Menopausal
- Length of Menses _____ # of days
- Monthly Cycle _____ # of days
- PMS:
 - Irritability
 - Fatigue
 - Emotional
 - Breast Tenderness/Swelling
 - Other _____
- Vaginal discharge or itching
- # Pregnancies _____
- # Live Births _____
- Menopause Symptoms:
 - Hot flashes
 - Night sweats
 - Dryness
 - Other _____
- Date last Mammogram _____
 - Normal Abnormal
- Date last Pap Smear _____
 - Normal Abnormal

Integumentary (Skin / Breast)

Immune System

- Rash, itching, hives
- Dry skin
- Eczema or Psoriasis
- Change in skin, hair or nails
- New or changing moles
- Breast pain or discharge
- Breast lump
- Allergies:
 - Food
 - Seasonal
 - Environmental
 - Immune Deficiency/Compromise