Carrie Abair - Licensed Acupuncturist

Patient Information (page 1 of 3)

NAME: (Last) _____ (First) _____ DATE: ___/___/____

PHONE: (Home) _____ (Work) _____ (Cell) _____ EMAIL: _____

SEX: M / F D.O.B.: ___/___/___ MARITAL STATUS: _____ EMPLOYER: _____

HOME ADDRESS:

_____

_____

City State Zip

EMERGENCY CONTACT
Name: _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION
Company Name: _____ Policy Number: _____
Policy Holder (if not patient): _____

REFERRED BY: _____

WHAT HEALTH CONCERN(S) ARE YOU SEEKING TREATMENT FOR?

_____

_____

ONSET DATE: ____/____/____

LIST OTHER TREATMENTS THAT HAVE HELPED THE CONDITION(S):

_____

_____

WHAT DO YOU FIND MAKES IT WORSE?

_____

_____

HAVE YOU EVER HAD ACUPUNCTURE BEFORE? Y / N

LIST ANY PHARMACEUTICAL DRUGS OR HERBS YOU ARE CURRENTLY TAKING:

_____

_____

_____

LIST ANY SURGERIES, ACCIDENTS OR INJURIES YOU HAVE HAD (Month/Year):

_____ (____/____)
_____ (____/____)
_____ (____/____)

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Please check all that apply.

GENERAL
___chills ___fevers ___low energy/fatigue ___night sweats ___spontaneous sweating
___aversion to heat ___aversion to cold ___recent weight loss ___recent weight gain
___susceptible to colds and flu - approximately how many times per year: _____

EYES/EARS
___floaters ___blurry vision ___pain behind ___eyes dry eyes ___inflamed eyes/redness tearing
___cataract ___glaucoma ___infection ___earache ___ringing in ears ___discharge from ear
Other: _____

HEADACHE
___headaches - region of head (ex., forehead, sides): _____
___migraines ___tight band headache ___dull headache ___sharp headache ___headache/nausea
Other: _____

RESPIRATORY
___asthma ___difficulty inhaling ___difficulty exhaling ___tightness in chest
___ph1egm in lungs - color, if any: _____ able to bring it up: Y / N
___sensation of something stuck in throat ___coughing up blood ___hoarseness ___loss of voice
___pneumonia ___current history of pneumonia ___hay fever/allergies ___sinus congestion
___loss of sense of smell ___nasal mucus - color, if any: _____
Other: _____

CARDIOVASCULAR
___chest pain/angina ___palpitations ___high blood pressure ___low blood pressure
___irregular heartbeat ___hypochondriac pain (pain under ribs) ___cold hands or feet
___poor circulation ___ankle swelling ___history of heart attack/heart failure
Other: _____

GASTROINTESTINAL
___difficulty swallowing ___bloating ___belching ___gas ___abdominal distention
___constipation ___diarrhea ___burning sensation ___diarrhea ___blood in stools ___black stools
___undigested food in stools ___candida/yeast infections ___irritable bowel syndrome ___gout
___hemorrhoids ___no appetite ___insatiable appetite ___nausea ___acid regurgitation/heartburn
___thirst - is thirst quenched after drinking: Y / N preferred drink: Hot / Cold
Other: _____

URO-GENITAL
___Urination - profuse amount urgent/bladder control problem ___scanty amount
___cloudy frequent urination ___burning sensation ___urine with blood
___current urinary tract infection ___history of urinary tract infection ___genital pain/swelling
___genital sores ___impotence ___seminal emissions ___low sexual energy
Other: _____

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PAIN
Where is pain located? _____
___soreness ___dull ___sharp ___inflamed or swollen ___radiates - to where? _____
___better with cold ___better with heat ___worse in damp weather ___repetitive stress injury
___result of accident - if so, what type of accident? _____
Other: _____

NEUROLOGICAL
___sensation of numbness ___tingling sensation ___sensation of pins and needle
Location for any of these symptoms: _____
___tremors ___drowsiness ___fainting ___vertigo ___paralysis ___stroke ___seizures
___loss of balance ___dizziness
Other: _____

SKIN/HAIR
___acne ___eczema/psoriasis ___dryness ___oily skin ___bruise easily
___dark circles/bags under eyes ___sores lumps - specific area: _____
___brittle nails ___dry hair ___hair loss

EMOTIONAL
___anxiety ___anger ___depression ___difficulty concentrating ___fear ___nightmares ___irritable
___insomnia ___trouble going to sleep
___interrupted sleep - what time do you wake up? ___:00
Other: _____

WOMEN
Age at onset of menses: _____ length of cycle (ex. every 28 days): _____ # of pregnancies: _____
Blood Quality: ___dark/purple ___bright red pale/pink ___clots ___scanty ___heavy
___premenstrual tension ___constipation or diarrhea - Before / During menses
___feeling of fatigue - Before / After menses_
___history of yeast infections/candida ___sores on genitalia ___painful periods ___fibroids
___ovarian cysts ___endometriosis ___abnormal pap smear ___uterine prolapse ___hysterectomy
___c-section ___breast tenderness ___breast lumps
Other: _____

Method of contraception, if applicable: _____

Are you in the process of trying to conceive? Y / N If so, how long? _____

Please describe any fertility issues:
_____
_____

Patient's Signature: _____ Date: _____