



**CONFIDENTIAL - NEW PATIENT
INFORMATION SHEET**

CONTACT INFORMATION

Name: _____ Date: _____

Address: _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Mobile: _____

Email _____

I wish to be contacted in the following manner:

(check all that apply)

- Home phone Work phone
 Email Written

May we email to remind you of your upcoming appointments?

- Yes No

Would you like to receive email regarding clinic discounts and special events?

- Yes No

How did you hear about PIHMA:

- | | |
|---|---|
| <input type="checkbox"/> Patient | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Brochure | <input type="checkbox"/> Staff/Faculty |
| <input type="checkbox"/> Google Search | <input type="checkbox"/> Talk/Speaking Engagement |
| <input type="checkbox"/> Intern/Student | <input type="checkbox"/> Yahoo Search |
| <input type="checkbox"/> Special Event | <input type="checkbox"/> PIHMA Event |
| <input type="checkbox"/> TV/Radio | <input type="checkbox"/> Outside Practitioner |
| <input type="checkbox"/> Newspaper: | <input type="checkbox"/> Other: |

PIHMA *does not* release protected health information (PHI) and/or sensitive health information over the phone, via electronic mail, or via written communication without patient written authorization. If we need to communicate protected health information to you we will contact you to schedule a consultation appointment.

From time to time we may phone, email or post general information such as updates and alerts, notification of clinic and/or college special deals, and reminders of upcoming appointments. PIHMA will never sell or distribute your contact information. Your contact information is for internal use only.

NEW CONFIDENTIAL PATIENT INFORMATION SHEET

PATIENT INFORMATION

Name: _____

Height _____ Weight _____ Age _____ Sex: Male Female

Date of birth: _____ Marital Status: _____

Number of children: _____ Ages of children: _____

Occupation _____ Employer _____

In emergency notify (name): _____ Emergency phone number: _____

Primary Care Physician (if appropriate): _____ Last seen: _____

MEDICAL COMPLAINT

Reason for your visit here today: _____

How long have you had this condition? _____

Have/are you being treated for this condition by another health care practitioner?: Yes No

Has this condition been diagnosed by a MD? Yes (Diagnosis: _____) No

Have these treatments helped? Yes Somewhat Not much Not at all

Have you had acupuncture before? Yes No

Do you currently have any infectious diseases? Yes No Possibly

If Yes, please identify: _____

MEDICAL HISTORY

Please check all that apply:

<p><u>Cardiovascular</u> <u>Conditions:</u></p> <p><input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema</p>	<p><u>Emotional / Mental:</u></p> <p><input type="checkbox"/> Anxiety / Fear <input type="checkbox"/> Anger / Frustration <input type="checkbox"/> Grief / Sadness <input type="checkbox"/> Lack of Joy / Mania <input type="checkbox"/> Worry / Over-thinking <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia</p>	<p><u>Energy & Immunity:</u></p> <p><input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies</p>	<p><u>Endocrine:</u></p> <p><input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold</p>
<p><u>Musculo-Skeletal:</u></p> <p><input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain</p> <p><u>Liver Conditions:</u></p> <p><input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C</p>	<p><u>Head, Eye, Ear, Nose & Throat:</u></p> <p><input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever</p>	<p><u>Genito-Urinary Tract:</u></p> <p><input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence</p>	<p><u>Gastrointestinal:</u></p> <p><input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Epigastric / Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Leaky Gut Syndrome</p>
<p><u>Neurological:</u></p> <p><input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Dyslexia <input type="checkbox"/> Insomnia <input type="checkbox"/> Poor Memory</p>	<p><u>Respiratory:</u></p> <p><input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath</p>	<p><u>Other:</u></p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Hemophilia</p>	<p><u>Other (continued):</u></p> <p><input type="checkbox"/> Significant Trauma Type: _____ <input type="checkbox"/> Significant Dental Work <input type="checkbox"/> Alcoholism <input type="checkbox"/> AIDs/HIV <input type="checkbox"/> Childhood illnesses <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Mumps</p>
<p><u>Surgical History:</u></p>		<p><u>Allergies or Pharmaceutical Reactions:</u></p>	

MEDICAL HISTORY (CONTINUED)

Family History:			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Obesity	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hypertension	
Men Only:			
<input type="checkbox"/> Impotence	<input type="checkbox"/> Vasectomy Date: _____	<input type="checkbox"/> Prostate problems	
<input type="checkbox"/> Testicular Pain / Redness / Swelling	<input type="checkbox"/> Seminal emissions		
<input type="checkbox"/> Low libido	<input type="checkbox"/> Excessive libido	<input type="checkbox"/> Painful Intercourse	
Women Only:			
Are you pregnant right now? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Trying <input type="checkbox"/> Maybe Method of Birth Control: _____			
Age at first period: _____ Start Date of last menses: _____ Age at menopause: _____			
Typical length of menses (days): _____ Typical length of cycle (from 1 st day to 1 st day of menses): _____			
Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____			
Hysterectomy: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____		Menopause: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Check all that apply:</i>			
<input type="checkbox"/> Low libido	<input type="checkbox"/> Excessive libido	<input type="checkbox"/> Painful Intercourse	<input type="checkbox"/> Clotting
<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Heavy Flow	<input type="checkbox"/> Scanty Flow	<input type="checkbox"/> Inter-Cycle Bleeding
<input type="checkbox"/> Irregular Cycles	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/> Nipple Discharge
<input type="checkbox"/> Infertility	<input type="checkbox"/> Moodiness	<input type="checkbox"/> PMS	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Fibroids	<input type="checkbox"/> Fibrocystic Breasts	<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Abnormal Pap Smear

PHARMACEUTICALS AND SUPPLEMENTS

Please list the medications and supplements you are currently taking:

Drug / Supplement	Reason for taking	For how long	Dose	Frequency
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I am taking Coumadin / Warfarin Yes No I am taking Plavix/ Aspirin Yes No

I have a pacemaker Yes No

LIFESTYLE

Are you... Vegetarian? Vegan? Have you ever been on a restricted diet? Yes No

Do you consume alcohol? Yes No How often do you drink alcohol? _____ How Much?: _____

Are you a smoker? Yes No How long have you been a smoker? _____

How would you rate the following areas of your health in the past month:

Energy: Great Good Fair Poor Comments: _____

Sleep: Great Good Fair Poor Comments: _____

Diet: Great Good Fair Poor Types of Food: _____

Exercise: Great Good Fair Poor Comments: _____

Immunity: Great Good Fair Poor Comments: _____

LIFESTYLE (CONTINUED)

How do you feel about the following areas of your life in the past month:

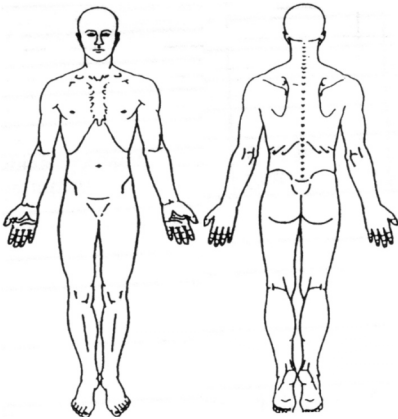
- Significant Other: Great Good Fair Poor N/A Comments: _____
- Family: Great Good Fair Poor N/A Comments: _____
- Sex Life: Great Good Fair Poor N/A Comments: _____
- Self: Great Good Fair Poor N/A Comments: _____
- Work: Great Good Fair Poor N/A Comments: _____

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

PAIN

Please answer the following questions if you have pain.

Indicate on the diagram on the left areas of pain:



- Quality of pain: Dull Sharp Stabbing Sore Cramping
 Burning Constant Fixed Moves about

On a scale of 1 – 10 (10 being worst) how strong is your pain? _____

Does the pain radiate? Yes No Where? _____

- What helps the pain? Ice Heat Rest Movement Pressure
 Moisture Massage Nothing Other: _____

What aggravates the pain? Ice Heat Rest Movement Pressure
 Moisture Massage Nothing Other: _____

Other treatments you have had for your pain?

Cause of pain? Injury / Accident Disease Unknown

Comments? _____

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 PIHMA Acupuncture Clinic 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____