PIHMA
ACUPUNCTURE
COLLEGE & CLINIC

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: ☐ Home phone ☐ Work phone
(check all that apply) ☐ 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:

- ☐ Patient
- ☐ Brochure
- ☐ Google Search
- ☐ Intern/Student
- ☐ Special Event
- ☐ TV/Radio
- ☐ Newspaper: _____
- ☐ Yellow Pages
- ☐ Staff/Faculty
- ☐ Talk/Speaking Engagement
- ☐ Yahoo Search
- ☐ PIHMA Event
- ☐ Outside Practitioner
- ☐ 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:

Cardiovascular Conditions:
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ A Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:
- ☐ Anxiety / Fear
- ☐ Anger / Frustration
- ☐ Grief / Sadness
- ☐ Lack of Joy / Mania
- ☐ Worry / Over-thinking
- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ ADD or ADHD
- ☐ Panic Attacks
- ☐ Alzheimer's
- ☐ Dementia

Energy & Immunity:
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Endocrine:
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

Musculo-Skeletal:
- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

Liver Conditions:
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Head, Eye, Ear, Nose & Throat:
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems
- ☐ Hay Fever

Genito-Urinary Tract:
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Incontinence

Gastrointestinal:
- ☐ Stomach Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Epigastric / Abdominal Pain
- ☐ Passing Gas
- ☐ Heartburn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Leaky Gut Syndrome

Neurological:
- ☐ Vertigo / Dizziness
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy
- ☐ Dyslexia
- ☐ Insomnia
- ☐ Poor Memory

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Other:
- ☐ Cancer
- ☐ Type:_____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Hemophilia

Other (continued):
- ☐ Significant Trauma
  Type:_____
- ☐ Significant Dental Work
- ☐ Alcoholism
- ☐ AIDs/HIV
- ☐ Childhood illnesses
  - ☐ Chicken Pox
  - ☐ Measles
  - ☐ Mumps

Surgical History:

Allergies or Pharmaceutical Reactions:

Medical History (continued)

Family History:

☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease
☐ Obesity ☐ Stroke ☐ Hypertension

Men Only:

☐ Impotence ☐ Vasectomy Date: _____ ☐ Prostate problems
☐ Testicular Pain / Redness / Swelling ☐ Seminal emissions
☐ Low libido ☐ Excessive libido ☐ Painful Intercourse

Women Only:

Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ 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 1st day to 1st day of menses): _____
Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____
Hysterectomy: ☐ Yes ☐ No Date: _____ Menopause: ☐ Yes ☐ No

Check all that apply:

☐ Low libido	☐ Excessive libido	☐ Painful Intercourse	☐ Clotting
☐ Painful Periods	☐ Heavy Flow	☐ Scanty Flow	☐ Inter-Cycle Bleeding
☐ Irregular Cycles	☐ Vaginal Discharge	☐ Breast Tenderness	☐ Nipple Discharge
☐ Infertility	☐ Moodiness	☐ PMS	☐ Endometriosis
☐ Fibroids	☐ Fibrocystic Breasts	☐ Ovarian Cysts	☐ 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 Coumadidn / 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:_____

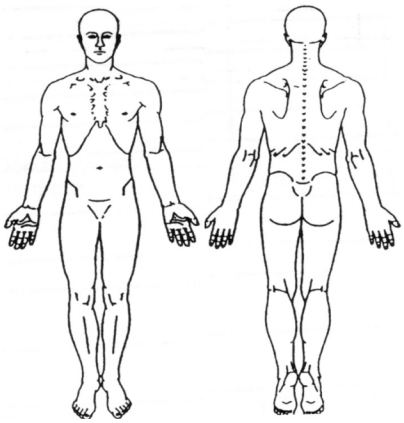
Self: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments:_____

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) _____