Ashley Wren Acupuncture

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New Patient Registration & Health History

Name _____ Today's Date _____

Street Address _____ Unit _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Preferred method of contact? _____ Would you like to receive our email newsletter? YES NO

Date of Birth (please include year) _____ Sex _____ Gender _____

SSN _____-_____-_____ Driver's License State _____ Number _____

Occupation _____ Employer _____

Marital Status _____ Referred by _____

Emergency Contact: Name _____ Phone _____

Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care?

Name _____ Phone _____

Name _____ Phone _____

Are you currently/within the last year been under the care of a healthcare professional? YES NO

If yes, for what? _____

Health History:

Have you had acupuncture before? _____ If so, for what reason? _____

Main reason(s) you are seeking treatment and length of time experiencing each:

CONCERN	FOR ABOUT HOW LONG?

Diagnosis from a medical professional and approximate dates of diagnosis (if applicable):

DIAGNOSIS	APPROXIMATE DATE

Current medications/herbs/supplements (please list *why*, *dosages* & *how long* you have been taking each):

_____

_____

_____

_____

_____

_____

_____

Allergies (medications/foods/chemicals/etc.) or sensitivities:

_____

_____

_____

Have you ever had a seizure? If yes, indicate dates of first and last: _____

Please circle any significant illnesses and indicate date:

Cancer Hepatitis Diabetes

High/low blood pressure Seizures/Epilepsy Heart Attack

Stroke Kidney Disease Liver/GB Disease

HIV/AIDS Anemia Other _____

_____

Please list any major surgeries/hospitalizations/injuries and approximate dates:

_____

_____

_____

Do you have a pacemaker? _____

Do you have any metal implants (ex. plate and screws)? _____

Family Medical History:

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Disease □ Hepatitis □ Asthma □ Other _____

Who in your family? _____

Lifestyle:

Do you have an exercise routine? If so, how often and what activity(ies)?:

_____

_____

Do you follow any certain diet (vegetarian, gluten-free, paleo, etc.) or have any restrictions?

_____

_____

What do you eat in a typical day? _____

_____

_____

How much water do you drink per day? _____ Do you drink coffee, tea and/or soda? _____

If yes, what and how much? _____

Do you or have you ever used tobacco? _____ If yes, how much? _____

Do you drink alcohol? If so, how many drinks/week? What do you drink?

_____

What about recreational drugs? If so, how often and what substance(s)?

_____

What are your goals for your health? _____

_____

For Women Only:

	past	current		past	current
irregular periods	☐	☐	vaginal discharge	☐	☐
painful periods	☐	☐	vaginal pain	☐	☐
bleeding between periods	☐	☐	hot flashes/ night sweating	☐	☐
period clots	☐	☐	nipple discharge	☐	☐
breast lumps/tenderness	☐	☐	other	☐	☐

Please explain further _____

_____

Age of first menses _____ How many days in a typical period _____ Date of last period _____

Duration of typical cycle (ie 28 days) _____ Date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

Sexually active? YES NO If yes, method(s) of protection _____

Might you currently be pregnant, are pregnant, or breastfeeding? YES NO If yes, please elaborate _____

_____

Any premenstrual &/or menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)? _____

_____

Have you been through menopause? _____ If yes, at what age? _____

Did you experience a difficult menopause? If so, please elaborate _____

_____

For Men Only:

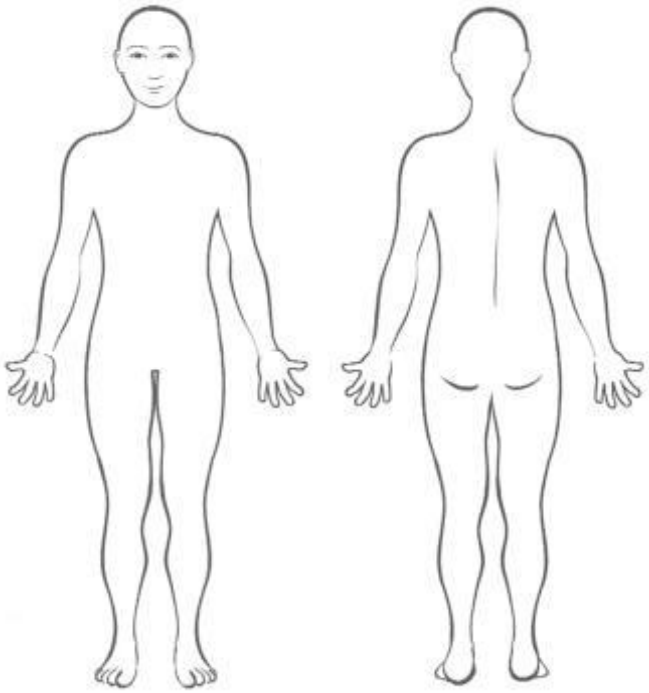
	past	current		past	current
erectile dysfunction/impotence	☐	☐	BPH	☐	☐
varicocele	☐	☐	night sweating	☐	☐
ejaculatory pain	☐	☐	hot flashes	☐	☐
hernia	☐	☐	testicular pain	☐	☐
penile discharge	☐	☐	other	☐	☐

Please explain further _____

Sexually active? YES NO If yes, method(s) of protection _____

FOR PAIN CONDITIONS:

Please mark any areas of pain or discomfort:



Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

_____

_____

_____

Please <u>check</u> any items listed below that you have experienced <u>in the last year</u> or that you feel are a significant part of your medical history:

General

	past	**current**		**past**	**current**
sweating easily during the day	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble falling asleep	☐	☐
dizziness/vertigo	☐	☐	trouble staying asleep	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐

fevers	☐	☐	bleed or bruise easily	☐	☐
chills	☐	☐	autoimmune disease	☐	☐

Please elaborate:

Skin, Hair & Nails

	past	**current**		**past**	**current**
rashes/hives	☐	☐	loss of hair/thinning hair	☐	☐
dry skin	☐	☐	fungal infections	☐	☐
oily skin	☐	☐	skin discoloration	☐	☐
itchy skin	☐	☐	recent moles	☐	☐
eczema	☐	☐	ulcerations	☐	☐
psoriasis	☐	☐	weak or rigid nails	☐	☐
face flushing	☐	☐	other	☐	☐

Please elaborate:

Head, Ears, Eyes, Nose & Throat

	past	**current**		**past**	**current**
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus problems	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	sores on the lips/tongue	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
environmental allergies	☐	☐	sore throat	☐	☐
vision loss	☐	☐	other	☐	☐

Please elaborate:

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐	other	☐	☐

Please elaborate:

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	pneumonia	☐	☐
chest tightness	☐	☐	bronchitis	☐	☐
cough/wheeze	☐	☐	tuberculosis	☐	☐
asthma	☐	☐	nasal congestion	☐	☐
coughing blood	☐	☐	phlegm production	☐	☐
COPD/emphysema	☐	☐	frequent colds	☐	☐
shortness of breath	☐	☐	other	☐	☐

Please elaborate:

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐
STD	☐	☐	yeast infections	☐	☐
bacterial vaginosis	☐	☐	other	☐	☐

Please elaborate:

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	Multiple Sclerosis	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
Alzheimer's	☐	☐	ADD/ADHD	☐	☐
Parkinson's	☐	☐	other	☐	☐

Please elaborate:

Digestive

	past	current		past	current
heartburn	☐	☐	stomach ulcers	☐	☐
diarrhea	☐	☐	Diverticulitis/IBS	☐	☐
constipation	☐	☐	ulcerative colitis	☐	☐
bloating	☐	☐	SIBO	☐	☐
nausea/vomiting	☐	☐	blood in/on stool	☐	☐
abdominal pain/cramps	☐	☐	Crohn's	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐
leaky gut syndrome	☐	☐	other	☐	☐

Please elaborate:

Please list any other relevant information or issues you would like to discuss: