The People's Acupuncture of Asheville
55 Grove St. Asheville, NC 28801
phone (828) 254-4098
peoplesacupunctureavl@gmail.com

PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birth Date_____

Occupation_____

CONTACT INFORMATION

Phone Number _____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Phone Number _____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1. _____
2. _____
3. _____

How is your sleep? _____

_____

How is your digestion?

_____

_____

List medications or food supplements you are taking.

_____

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

_____

Past and current treatments used for primary concerns.

_____

_____

Check symptoms you have or have had in the last year:

___ Depression
___ Headache
___ Dizziness
___ Easily startled
___ Nervousness
___ Irritability
___ Overwhelmed by life
___ Difficulty in focusing
___ Excessive fear
___ Excessive worry
___ Fatigue/tiredness
___ Excessive anger
___ Loss of/poor sleep
___ Loss/gain of weight

Check conditions you have or have had in the past:

___ Allergies
___ Anemia
___ Bleeding disorders
___ Breast lump
___ Cancer
___ Diabetes
___ Arthritis
___ AIDS

How long has it been since you've had a complete medical exam? _____

Check illnesses that have occurred in blood relatives.

___ Diabetes
___ Stroke
___ Cancer
___ High blood pressure
___ Kidney disease
___ Heart disease

TURN OVER

HEALTH HISTORY (CONT.)

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

___ Tremors ____Cramps ___ Swollen Joints

Pain, weakness, numbness in:

___ Arms or hips
___ Back of legs
___ Feet
___ Neck
___ Hands
___ Shoulders

Other_____

THROAT/RESPIRATORY/EARS/NOSE/EYES

___ Asthma/wheezing
___ Difficulty breathing
___ Sinus problems
___ Frequent sinus infections
___ Persistent cough
___ Allergies
___ Hoarseness
___ Frequent colds
___ Gum trouble
___ Eye pain
___ Blurred or failing vision
___ Enlarged glands
___ Ringing in ears
___ Loss of hearing
___ Earache
___ Nose bleeds

SKIN

___ Boils
___ Bruise easily
___ Dry skin
___Eczema, psoriasis, dermatitis
___ Sensitive skin
___ Sore won't heal
___ Itching/rash
___ Acne/cysts

CARDIOVASCULAR

___ Previous heart attack
___ Hardening of arteries
___ Poor circulation
___ Ankle swelling
___ Chest pain
___ High or low blood pressure
___ Rapid/Irregular heart beat
___ Pain over heart

IMPLANTED MEDICAL DEVICES

___ Metal screws, pins, plates, or rods
Where? _____

___ Pacemaker/defibrillator ___ Stents

Other_____

GASTROINTESTINAL

___ Pain over stomach
___ Gall bladder trouble
___ Hemorrhoids
___ Difficulty swallowing
___ Belching, gas, bloating
___ Acid Reflux
___ Constipation
___ Gurgling
___Cramping
___ Nausea
___ Diarrhea
___ Poor appetite
___ Colon trouble
___ Indigestion
___ Excessive hunger

GENITO/URINARY

___ Blood/pus in urine
___ Kidney infection/stones
___ Incontinence
___ Frequent urination
___ Lowered libido

___ Erection difficulties
___ Prostate trouble
___ Penis discharge

___ IUD
___ Previous miscarriage
___ Traumatic childbirth
___ C Section
___ Excessive blood loss from childbirth
___Regular period
___Extremely painful
___Too frequent
___Bleeding in between
___Cysts or fibroids
___ Extreme PMS
___ Currently use birth control pill
___ Perimenopausal symptoms
___ Menopausal
___ Hysterectomy
___ Irregular period
___ Scanty
___ Excessively heavy period
___ Pain with ovulation

How many childbirths have you had? _____

Could you be pregnant? _____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ Date_____