The People's Acupuncture of Asheville
55 Grove St. Asheville, NC 28801
phone (828) 254-4098
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PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birth Date _____

Occupation _____

Company name _____

Primary physician _____

Physician phone number_____

How did you hear about us?_____

CONTACT INFORMATION

Home phone_____

Work phone_____

Other/cell phone _____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Home phone _____

Work phone_____

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

TURN OVER

HEALTH HISTORY (CONT.)

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

MUSCLE/JOINT/BONES

___ Tremors c 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
___ Persistent cough
___ Enlarged glands
___ Ringing in ears
___ Loss of hearing
___ Earache
___ Hoarseness
___ Hay fever
___ Frequent colds
___ Nose bleeds
___ Gum trouble
___ Eye pain
___ Blurred or failing vision

SKIN

___ Boils
___ Bruise easily
___ Dry skin
___ Sensitive skin
___ Sore won't heal
___ Itching/rash

GENITO/URINARY

___ Blood/pus in urine
___ Kidney infection/stones
___ Inability to control urine
___ Frequent urination
___ Lowered libido

SOCIAL HISTORY

___ Smoking
___ Drinking
___ Recreational drugs
___ Caffeine

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

GASTROINTESTINAL

___ Pain over stomach
___ Gall bladder trouble
___ Hemorrhoids (piles)
___ Difficulty swallowing
___ Distention of abdomen
___ Belching, gas, bloating
___ Nausea
___ Diarrhea
___ Poor appetite
___ Colon trouble
___ Indigestion
___ Excessive hunger

___ Erection difficulties
___ Penis discharge
___ Prostate trouble

___ Menopausal symptoms
___ Extreme menstrual pain
___ Previous miscarriage
___ Scanty flow
___ Excessive flow
___ Irregular cycle
___ PMS
___ Bleeding between periods

Could you be pregnant? _____

IMPLANTED MEDICAL DEVICES

___ Metal screws, pins, plates, or rods
___ Pacemaker/defibrillator ___ Stents

Other _____

SIGNATURE

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

Signature_____ Date _____