# STONEBURNER ACUPUNCTURE, LLC

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Date: _____

Name: _____
(First) (Middle) (Last)

DOB: _____ Age: _____ Sex: _____

Address: _____ City/State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

May messages be left on one or both of these numbers? Yes No

E-Mail: _____ Social Security # _____

Occupation: _____ Employer:_____

Primary Care Physician: _____ Insurance Provider: _____

Policy Number: _____ ID Number: _____

**Emergency Contact**: (name, telephone, relation): _____

_____

How did you hear about us? _____

Please identify the health concerns (past or present) that have brought you into the clinic:

| Condition | Treatments Received |
|---|---|
| 1. _____ | |
| 2. _____ | |

3. _____
_____

4. _____
_____

5. _____
_____

Please list any **foods, medications, or drugs** you are hypersensitive or allergic to (including reactions):

_____

Please list any **medications, vitamins or supplements** you are currently taking (including dosages):

_____

Do you have any reason to believe you may be **pregnant**? Yes No

If yes, how far along are you? _____

Do you have any **infectious diseases**? Yes No

If yes, please identify: _____

**Blood Pressure**: What was your most recent reading? _____/_____

When was this taken? _____

**Height**: _____ **Weight** (Current): _____ Past Maximum: _____ When? _____

**Male Only**:

a. Prostate concerns? _____
PSA level, if applicable: _____

b. Painful urination? _____

c. Decreased stream? _____

d. Discolored urine? _____

e. Impotence? _____

f. Testicular Pain/Swelling: _____

Any other male concerns your practitioner should be aware of?

_____

**Female Only**:

**Gynecological History**:

a. Age of First Menses: _____

b. Number of Days of Flow: _____

c. Length of Cycle: _____

d. Date of last menstruation: _____

f. Menstrual cramping? _____

g. PMS? _____

k. Number of Pregnancies: _____

l. Number of Live Births: _____

m. Number of Miscarriages: _____

n. Number of Abortions: _____

o. Birth Control Type: _____

s. Onset of Menopause:_____

Any other gynecological information your practitioner should be aware of?

_____

_____

**Hospitalizations and Surgeries**:

| Reason | When | Reason | When |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |

| **Family History**: | Father | Mother | Brothers | Sisters | Grandparents |
|---|---|---|---|---|---|
| Cancer (Please note type) | _____ | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ | _____ |
| Mental Illness | _____ | _____ | _____ | _____ | _____ |

Asthma _____ _____ _____ _____ _____

**Lifestyle**:

a. Do you typically eat three meals per day? Y / N If no, how many? _____

b. Do you feel you have a healthy diet? Y / N

c. Do you have particular food cravings? _____

d. Exercise routine: _____

e. On average, how many hours per night do you sleep? _____ Do you wake rested? _____

g. Do you smoke?_____ How much?_____

h. What is your caffeine intake? _____

i. How much alcohol do you consume? _____

For the conditions listed below, please **CIRCLE** any that you have now and **UNDERLINE** any you have experienced in the past:

**Emotional**
Mood Swings
Anxiety
Depression
Stress

**Energy & Immunity**
Fatigue/Low Energy
Chronic Fatigue Syn.
Insomnia
Frequent colds and flu
Slow Wound Healing

**Musculoskeletal**
Neck/Shoulder Pain
Muscle Tension
Muscle Spasms
Back Pain
Headaches
Fibromyalgia
Joint Pain
Stiffness
Restless Legs
Leg Cramps
Sprains/Strains
Tendonitis
Arthritis

**Eye, Ear, Nose and Throat**
Impaired Vision
Poor Night Vision
Floaters
Eye Pain/Strain
Glaucoma
Glasses/Contacts
Excessive Tearing
Redness/Dryness
Ringing In The Ears
Ear Aches
Sinus Problems
Allergies
Frequent Sore Throats
Teeth Grinding
TMJ

**Cardiovascular**
Heart Disease
Chest Pain
Palpitations/Fluttering
High Blood Pressure
Stroke
Heart Murmurs
Varicose Veins
DVT
Cold Hands and Feet
Anemia

**Gastrointestinal**
Ulcers
Low Appetite
Excessive Hunger
Nausea/Vomiting
Abdominal Pain
Flatulence
Bloating
Acid Reflux
Belching
Chronic Constipation
Chronic Diarrhea

IBS
Hemorrhoids
Food Sensitivities

**Genital/Urinary Tract**
Painful Urination
Frequent/Urgent Urination
Frequent UTI
Burning/Pain with Urination
Blood in Urine
Kidney Disease
Kidney Stones
Wake At Night to Urinate
Irregular Menses
Heavy Bleeding
Complications with Pregnancy
Infertility
Impotence

**Neurological**
Vertigo
Dizziness
Numbness/Tingling
Loss of Balance
Seizures
Trigeminal Neuralgia
Stroke
Shingles
MS

**Endocrine**
Hypothyroid
Hyperthyroid
Diabetes
Night Sweats
Low Libido

**Respiratory**
Asthma
Shortness of Breath
Wheezing
Emphysema
Bronchitis

**Addictions**
Alcohol
Cigarettes
Narcotics
Marijuana

**Other**
_____
_____
_____
_____