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NEW PATIENT INFORMATION

This is a confidential record of your medical history. Information contained here will not be released to any person(s), except when you have given written consent to do so.

Today's Date: _____/_____/_____

GENERAL INFORMATION

Legal Name _____ Preferred Name/Nickname _____

Date of Birth _____ Gender Identity/Pronoun(s) _____

Address _____ City _____ State _____ Zip Code _____

Preferred Phone Number (_____)_____ Ok to leave a medical related voicemail at this number? ____Y ____ N

Email address _____ Ok to send medical related messages to this email? ____Y ____ N

Occupation(s) _____

Are you active military? _____Y _____ N Are you a US Veteran? _____Y _____ N

Minors Under 18 - Parent/Responsible Party Information

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number (_____)_____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____

Phone Number (_____)_____

HEALTHCARE PROVIDERS

Do you have a primary care doctor that you see annually? _____Y _____N OB-GYN and/or Midwife? _____Y _____N

Are you currently under the care of a Dermatologist? _____Y _____N If yes, please explain: _____

List any specialist(s) you see _____

Other (Chiropractor, Massage Therapist, Physical Therapist, Psychotherapist, etc.) _____

BACKGROUND INFORMATION

Previous experience with acupuncture? _____Y _____N If yes, how long ago? _____

Previous experience with microneedling or nano needling? _____Y _____N If yes, how long ago? _____

Previous experience with cupping or gua sha? _____Y _____N If yes, how long ago? _____

What is your primary reason(s) for seeking treatment here at Colorado Acupuncture and Wellness? _____

_____

What are your treatment goals?_____

How did you hear about Colorado Acupuncture and Wellness? _____

MEDICAL AND HEALTH INFORMATION AND HISTORY

Have you been given any diagnoses by a physician? If so, please explain: _____

_____

Do you smoke or vape? _____Y _____N If yes, what, and how much/how often per day?_____

Do you drink alcohol? _____Y _____N If yes, how much and how often? _____

Do you drink caffeinated drinks? _____Y _____N If yes, what, and how much/how often per day?_____

Do you drink coffee? _____Y _____N If yes, how often and how much? _____

How much water per day do you drink? _____ How many hours of sleep per night do you get? _____

What time do you go to bed? _____ Do you have trouble falling asleep? _____Y _____ N

Do you wake up frequently? _____Y _____ N Do you have trouble staying asleep? _____Y _____ N

What time do you wake up? _____ Do you wake up feeling rested? _____Y _____ N

How many days per week do you exercise? _____0-1 _____1-2 _____2-3 _____3-4 _____4-5 _____5-6 _____6-7 _____7 days

Describe your average daily food/calorie intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What would you say your general health is like? _____

Are you satisfied with the state of your general health? _____Y _____ N If no, what is needed to make you feel satisfied? _____

_____

Describe your energy level:

____ *Low*; tired most of the time ____ *Fluctuating* between morning and afternoon ____ *High*; lots of energy and endurance

What time of day do you feel your best? _____ What time of day do you feel your worst? _____

What do you do for self-care or to de-stress? _____

Please list all medications, supplements and/or herbs that you are currently taking, along with the dosage, the frequency you take it, and the reason you are taking it.

Medication/Supplement/Herb	Dosage	Frequency	Why are you taking it?

Please list any surgeries and hospitalizations.

Event	When?

Please list any allergies, including medical, environmental, food, latex, etc, and the reaction from it.

Allergy	Reaction

Please list any illnesses, accidents, and any mental or emotional traumas.

	Illnesses	Accidents	Mental/Emotional Traumas
Birth and Infancy			
Childhood			
Teens			
Adulthood			

FAMILY HEALTH INFORMATION AND HISTORY

Are you adopted? _____ Y _____ N If yes, skip this section.

Please list any medical diagnoses, illnesses, and cause of death if applicable.

Mother	Father	Siblings	Grandparents	Children

Females (Assigned Female at Birth - AFAB) Only

Date of last PAP/Gynecological check up: _____ Results: _____

Age you began your period? _____ Are/were your periods regular? _____Y _____ N

Average number days in cycle: _____ Average number days of flow: _____ Spotting between periods? _____Y _____ N

Type of Flow: _____ Light _____ Medium _____ Heavy Blood clots? _____Y _____ N If yes, are they: _____ Small _____ Large

Color: _____ Pale _____ Dark _____ Bright Red _____ Light Red _____ Brown _____ Purple

Do you experience any menstrual symptoms: _____Headaches _____Cramping _____Bloating _____Breast Sensitivities _____Irritability

Are you on birth control? _____Y _____ N If yes, what type: _____ For how long? _____

Do you experience any problems with it? _____Y _____ N If yes, please explain: _____

Have you had a hysterectomy? _____Y _____ N If yes, when was the procedure performed? _____

Any complications from the procedure? _____Y _____ N If yes, please explain: _____

Have you gone through menopause? _____Y _____ N If yes, age menopause began: _____

Are you on hormone replacement therapy? _____Y _____ N If yes, what type: _____

Have you ever experienced any of the following:

____ Vaginal swelling/pain ____ Yeast Infection ____ Non-yeast Vaginal Infection ____ UTI ____ Genital Herpes or Warts ____ STD's

____ Infertility ____ Decreased sex drive ____ Increased sex drive ____ Ovarian Cysts ____ Uterine Fibroids ____ Endometriosis

____ Pelvic Inflammatory Disease (PID) ____ Polycystic Ovary Syndrome (PCOS) ____ Breast Lumps ____ Abnormal PAP result

____ Abnormal Mammogram ____ Abnormal Nipple Discharge

Are you:
_____ Currently Pregnant _____ Trying to Conceive _____ Planning on Becoming Pregnant _____ Breastfeeding

Obstetrical History and Information

	Number	Your Age		Number	Your Age
Pregnancies			Miscarriages		
Live Birth Vaginal Delivery			Abortion		
Live Birth Cesarean Delivery			Still Births		

Any issues with pregnancy or delivery?

Males (Assigned Male at Birth - AMAB) Only

Date of last prostate check up: _____ Results: _____

Have you had a vasectomy? _____Y _____ N If yes, when was the procedure performed? _____

Any complications from the procedure? _____Y _____ N If yes, please explain: _____

_____

Have you ever experienced any of the following:

____ Testicular swelling/pain ____ Premature ejaculation ____ Nocturnal emissions ____ Discharge from penis ____ UTI ____ STD's

____ Prostate Problems ____ Impotence ____ Low sperm count ____ Decreased sex drive ____ Increased sex drive

Please mark any symptoms you currently have or have experienced in the past.

Liver/Gallbladder

- o Depression
- o Highly stressed
- o Headaches or migraines
- o Red eyes
- o Dry eyes
- o Itchy eyes
- o Visual problems such as blurred vision
- o Dizziness
- o Gallstones
- o Feeling of lump in throat
- o Clenching teeth at night
- o Muscle cramping or twitching
- o Neck/shoulder pain or tightness
- o Seizures or tremors
- o Poor circulation
- o Soft or brittle nails
- o Bitter taste in mouth
- o PMS or menstrual issues
- o Tendonitis
- o Pain below ribcage
- o Do you crave sour flavors?
- o Tend to be irritable or angry
- o Insomnia during 11pm-3am

Heart/Small Intestine

- o Heart palpitations
- o Rapid or irregular heartbeat
- o Chest pain
- o High blood pressure
- o Low blood pressure
- o Insomnia or sleeping problems
- o Vivid dreams or nightmares
- o Easily startled
- o Dark urine
- o Red complexion
- o Do you crave bitter flavors?
- o Anxiety, nervousness or restlessness

Spleen/Stomach

- o Feeling of body heaviness
- o Hard to get up in morning
- o Muscles often feel tired
- o Edema
  - o Hands o Feet
- o Easily bruises or easy bleeding
- o Bad breath
- o Sweetish taste in mouth
- o Lack of taste
- o Excess appetite
- o Low appetite
- o Excess thirst
- o Lack of thirst
- o Nausea
- o Vomiting
- o Gas or belching
- o Hemorrhoids
- o Organ Prolapse (i.e. uterus, bladder)
- o Chronic loose stools
- o Abdominal pain
- o Indigestion or heartburn
- o Brain fogginess
- o Mouth ulcers
- o Tendency to gain weight
- o Do you crave sweet flavors?
- o Tendency to over-think or over-worry

Lung/Large Intestine

- o Bloody cough
- o Dry cough
- o Chronic cough
- o Cough with sputum
- o Nasal discharge
  - o White o Yellow o Green
- o Post nasal drip
- o Sinus congestion or infection
- o Itchy, red, or painful throat
- o Dry mouth
- o Dry nose
- o Dry throat
- o Skin rashes or hives
- o Snoring
- o Shortness of breath
- o Allergies
- o Asthma
- o Low immunity
- o Catch colds easily
- o Bronchitis
- o Black or bloody stools
- o Constipation
- o IBS
- o Diarrhea
- o Colitis or spastic colon
- o Do you crave pungent or spicy flavors?
- o Extreme grief or sadness

Kidney/Urinary Bladder

- o Nighttime urinary problems
- o Bladder infection
- o Incontinence
- o Weakness or pain in low back
- o Osteoporosis
- o Gets/feels cold easily
- o Gets/feels hot easily
- o Cold Hands or feet
- o Dark circles under eyes
- o Thyroid problems
- o Poor memory
- o Hair loss
- o Grey hair
- o Hearing problems
- o Tinnitus
- o Cavities
- o Hot flashes
- o Night sweats
- o Do you crave salty flavors?