Patient Information

Name_________________________________Date:____________Address______________________________City _______________

State ____ Zip____________ Home phone ___________________ Cell ____________________Email ___________________________

DOB____/_____/______Occupation___________________________Emergency notify: _________________________ Emergency phone number: ___________________ Would you like to receive our newsletter? cYes c No

Please check all that apply:

Musculo-Skeletal:
- ☐ Neck pain
- ☐ Shoulder Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

Cardiovascular Conditions:
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:
- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety
- ☐ Alzheimer's

☐ **Energy & Immunity**:
- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies
- ☐ Hay Fever

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Head, Eye, Ear, Nose & Throat:
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems

Genito-Urinary Tract:
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence

Neurological:
- ☐ Vertigo / Dizziness
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy

Gastrointestinal:
- ☐ Stomach Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Epigastric / Abdominal Pain
- ☐ Passing Gas
- ☐ Heart Burn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea

Endocrine:
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Night Sweats
- ☐ Unusual Sweating

Liver Conditions:
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Gall Bladder:
- ☐ Removed
- ☐ Cystic
- ☐ Pain

Other:
- ☐ Cancer
  Type:_____________
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Cold Hands / Feet

Men Only:
- ☐ Impotence
- ☐ Vasectomy
  Date: _____________
- ☐ Prostate problems
- ☐ Testicular Pain / Redness / Swelling
- ☐ Low libido

Medical History

Chief complaint: ____

Diagnosed by an MD? ☐ Yes ☐ No (Diagnosis: ___________________________) How long have you had this condition? ___________

How does this condition affect you? ____

Accidents / Hospitalizations / Surgeries in the past 10 years:

Please list all prescription and over the counter medications you are currently taking ***(Use additional paper if necessary):***

Drug Name | Reason for taking | For how long

Physical Constitution/Build:

Height: ________ Weight: _________ Age: ________

Big-boned: ________ Medium-boned: ________ Small-boned: ________

Exercise pattern: ____

____

Pain
If you have pain, please fill out the following section describing the pain. If you have more than one area/type of pain, please describe each area/type separately. Please use the "Comments" section at the end of the form for this.

On a 1-10 scale, with "1" being least and "10" most, how severe is the pain? __________
Is the pain localized or diffuse? ____
Is the pain more stabbing, more sore, or alternating stabbing/sore? __________________
____
Please describe the pain in as much detail as you can: _____________________________
____
____
Is the pain worst at any particular time(s) of day? _______________________________
Is the pain worse or better with pressure/rubbing/massage? _________________________
Is the pain worse or better with the application of heat or cold? _____________________

Temperature
When you are with others who are comfortable in the prevailing temperature, do you tend to feel warmer than they do, cooler than they do, or the same? ___________ Overall, would you say that you tend to run hot, cold, or neither? ________________________________
Do you have a preference for cold drinks or hot drinks? If no preference, enter "NA".
____

Fever and chills: Fever only: _____ Chills only: ______ Alternating fever/chills: ______
Time of day fever/chills occur, if applicable: ___________________________________
How severe is the fever/chills? ____
If you have fever, do you sweat? ________ Profuse sweat, or mild? _________________
If you are sweating other than during exercise, what time of day? ___________________
Do you sweat easily with relatively minor exertion? __________

Energy
Overall energy level : ____
What time of day is your energy highest? __________ Lowest? __________

Elimination
Are your bowel movements regular? cYes c No Loose stools? cYes c No
Alternating constipation and diarrhea? cYes c No
Please describe the shape, texture, hardness of your stools: _________________________
____
Frequent urination? ________ Do you wake at night to urinate? _________

Do you experience any bitter, metallic or other taste in your mouth, especially upon waking? cYes c No
If so, what kind of taste? _____________________

Sleep
Do you have trouble falling asleep? ______ Staying asleep? ______
Do you feel refreshed upon awaking? ______

Women only:
Are you menstruating? _______________
Length of period: ___________________________
Bleeding pattern during period: ______________________

Color(s) of bleeding: ___________________________
Clots? _______ If so, how big? _____________________
PMS? ______ If so, severity: ___________________
Breast tenderness? ___________
Cramping? _______________
Pain during ovulation? _______________
Are you on birth control pills? cYes c No Other contraceptive? cYes c No
Are you on Hormone Replacement Therapy? cYes c No
Are you seeing an OB/GYN? cYes c No If so, for what? ________________________________
____

The above information is true to the best of my knowledge.

Signed: ____ Date: ____________

Disclaimer:

All herbal products are accompanied with directions for use. North Scottsdale Acupuncture is not responsible for the misuse of any herbal products, or advice, nor do we recommend herbs in place of your doctor's recommendations or prescriptions. All information and products are to be used ONLY AS DIRECTED. Do not combine herbal remedies with pharmaceutical drugs unless you have consulted your physician. Keep out of reach of children & pets, do not use during pregnancy or lactation.

Important Notice:

All sales are final as these products cannot be resold after leaving the clinic. Please ask questions ***before*** you purchase.

Informed Consent:

I understand that Chinese herbal products may carry a risk if not taken as directed or if taken during pregnancy or lactation. I understand that I am not required to take these products but I must follow the directions for administration if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I should suspend taking them and contact North Scottsdale Acupuncture as soon as possible.

By signing below, I do hereby voluntarily consent to engaging in supervised herbal therapy and using the products purchased from North Scottsdale Acupuncture only as directed, and I acknowledge that I have been informed of risks associated with using these products. I agree also to inform the herbalist at North Scottsdale Acupuncture immediately should any adverse symptoms appear after ingesting the herbal substance provided. I have read and understand everything on this form.

Signed: ____ Date: ____________

North Scottsdale Acupuncture
10250 N. 92nd Street, Suite 301
Scottsdale, AZ 85258
(480) 389-9030; Fax: (480) 452-0712
info@northscottsdaleacupuncture.com