Pain & Clinic
Acupuncture & Herb
2415 S. Glendale · Wichita, KS 67218
(316) 293-8459

New Patient Form

Date (M/D/Y)_____ **Height:** _____ **Weight**_____ **Race**_____

Last Name (Mr. Mrs. Ms. Miss._____ **(First Name)**_____

Birthday: M ___/D___/Y___ **Occupation** _____ **Referred by**_____

Single Married Partnership Divorced Widowed Separated others

Address: _____ City_____ **Zip:**_____

Home phone: _____ **Cell:** _____ **Work**_____

E-mail:_____

Emergency Contact: _____ **Phone:**_____

Employer: _____

Have you had Acupuncture before? No, Yes **Herbal Medicine?** Yes, No

Reason for today's visit:_____

_____

How long have you had this condition?

_____

What makes is better or worse?_____

_____

Your Medical Doctor's Info:_____

Medications you're currently taking_____

_____

Allergies:_____

Are you pregnant (or any possibility you're)? Yes, No, N/A

General Past Medical History: _____

_____

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Lifestyle related questions: (Circle or underline the below questions)

Diet: Vegetarian, More veggie & fruit, More protein & meat, Heavy on cabs?

Exceedingly hungry, Poor appetite, Hunger w/no desire to eat, Specific

cravings_____

Drinks: coffee, tea, pop, beer, alcohol? How much or how often? _____

Excessive thirst, Thirst w / no desire to drink, No thirst, Prefer cold / hot drinks.

Tobacco Use: Yes, No, How long and how many per day?_____

Habits: _____

Exercise: what type of exercise and how often? _____

Head Neck & Shoulders:

Dizziness, Vertigo, Headache, Migraine, Stiff neck, Earache, Tinnitus, Reduced

hearing, Dry eyes, Blurred vision, Floaters, Eye pain, Poor night vision, Sore

throat, Bleeding gums, Bitter taste in mouth, Dry mouth, Tongue ulcers, Difficulty

swallow, Lump in throat, Sinus, Nasal congestion, Nose bleeding, Stiff Neck,

Heavy and Tensed shoulders

Respiratory:

Chronic Cough, With phlegm, Difficulty inhaling, Shortness Breath,

Wheezing/Asthma, Seasonal allergy, Panting, Frequent Colds, Bronchitis, Hay

Fever, Spontaneous sweats, Night sweats, Hot flashes

Genital/Urinary:

Pain/itching of genitalia, Genital lesions/discharge, Painful/burning urination, Urgent Urination, Frequent urination, Excessive or scant urination, Blood in urine,

Unable to hold urine, Nighttime urination (once, twice, more), Increased libido,

Decreased libido, Kidney Stone.

Cardiovascular: BP:_____/_____, HR:_____(per minutes)

Heart palpitations, Chest pain/tightness, Poor circulation, Varicose veins,

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Irregular heart beat, Swelling feet/ankles, Pace maker or any other surgeries?

Muscles & Joints:

Joint pain (where?_____) Body aches /stiffness , General weakness, Numbness/ tingling sensations, "Heaviness" of body/limbs, Joint swelling, Motion restriction, Arthritis,

Skin:

Hives/Rashes, Acne, Dry skin, Eczema/psoriasis, Bruise easily, Itchy skin, Brittle/weak nails, Changes in moles/lumps, Hair loss,

Gastrointestinal:

Nausea, Hiccups, Acid reflux/heartburn, Bad breath, Vomiting, Bloating, Gas, Rectal pain/itchiness, Constipation, Loose/soft stool, Anal fissures, Hemorrhoids, Intestinal cramping, Alternating diarrhea/constipation, How many BM _____ per day usually?

Sleep: Hours ____ of sleep in 24 hours

Sound/restful, Trouble falling asleep, Trouble staying asleep, Wake easily/early, Dream Disturbed sleeping, Nightmares often, Difficulty waking up,

Emotions:

Relaxed/calm, Sad/Grief/depressed, Fearful, Impatient, Angry/Frustrated, Forgetful/poor memory, Anxious, Stressed easily, Manic, Swing back and forth,

General:

Cold hands/feet, Always feel hot, Always feel cold, Fever& Chills, Recent unexplained weight changes, Fatigue

Menses:

First Menses at age of____, How many days in cycle_____? How many pregnancies _____? How many alive _____?

Amenorrhea, Dysmenorrheal, Excessive flow, Scanty flow, Mid-cycle spotting, Cramping

Oral Contraceptive use? Yes, No First day of last period: _____

Approx date/or age of menopause:_____

Anything else you would like to address at this time:_____