



True Path Acupuncture

& Wellness ®

Date _____

New Patient Information

Personal Information

Name _____
Address _____

Home phone _____
Work or cell phone _____
Email _____
Birth date _____ Age _____

Number of children _____ Ages _____
Marital status _____
Occupation _____
Referred by _____
Physician name _____
Physician's phone _____
Emergency contact name _____
Relationship _____ Phone _____

Main Concerns

Please tell me about your major health and wellbeing concerns in order of how important they are to you. It will help if you include when and where you first noticed them and to what extent they affect your daily life now.

Have you received a diagnosis for your concerns? If yes, what was the diagnosis? _____

What kinds of treatment(s) have you tried or are currently using related to these concerns? _____

What results have you seen from the above treatments? _____

Please mark the severity of your chief concern today.

No problem _____ Worst imaginable
1 2 3 4 5 6 7 8 9 10

Please mark the greatest degree of severity of your chief concern that you have ever experienced.

No problem _____ Worst imaginable
1 2 3 4 5 6 7 8 9 10

Personal Medical History

Please mark all that apply and explain as necessary.

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Thyroid disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> HIV/AIDS _____ | <input type="checkbox"/> Other _____ |

Please date and describe all hospitalizations and surgeries _____

Please date and describe significant traumas _____

What do you know about your birth (prolonged labor, forceps, premature, etc.) _____

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.) _____

Have you undergone a course of antibiotics lately? _____

Have you been under the care of a licensed health care professional in the past year? _____

If so, for what reasons? _____

Family Medical History

Please mark which apply, elaborate as appropriate and indicate which family member.

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Drug/alcohol abuse _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Thyroid disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Mental disorder _____ | <input type="checkbox"/> Other _____ |

Review of Symptoms

General (Circle): Catch cold easily, Recurrent infections, Night sweats, Bleed or bruise easily, Organ prolapse, Strong thirst (hot or cold), Fatigue/low energy, Sudden drops of energy Time of day _____, Sudden Change in Weight, Other _____

Skin and Hair (Circle): Dry skin/scalp/hair, Rashes/hives, Itching, Eczema, Warts, Acne, Change in moles, Hair loss/thinning hair, Other _____

Sleep (Circle): Difficulty falling asleep, Wake up easily during the night - Times per night? _____ At a particular time? _____, Wake up too early in the am - What time? _____, Nightmares, Vivid dreams, Grinding teeth, Talking in sleep, Snoring, Other _____

Circulation (Circle): Cold hands or feet, Swelling of hands/feet, Blood clots, Varicose veins, Edema/swollen ankles, Puffy Eyes, Other _____

Head, Ears, Eyes, Nose, Throat (Circle): Headaches – Where _____ When _____, Migraines, Dizziness/vertigo, Fainting spells, Earache, Change in hearing, Ringing in the ears, Blurry vision, Night blindness, Color blindness, Spots before eyes, Dry eyes, Eye pain/sore eyes, Excessive tearing, Glasses/contacts, Facial pain, Facial paralysis, Nosebleeds, Blocked nose/sinuses, Sinus infections, Jaw pain, Teeth/gum problems, Recurrent sore throat, Hoarseness/loss of voice, Tonsillitis/swollen glands, Sores on lips/mouth/gums, Strange taste in mouth, Swollen glands/lumps, Oral ulcers,

Other _____

Nervous System (Circle): Loss of taste/smell/touch, Tingling sensations/numbness, Tremors - Where? _____, Lack of coordination/balance, Paralysis or seizures, Stroke, Concussion, Other _____

Chest (Circle): Pain in chest, Tightness or pressure in chest, Pain with breathing, Difficulty breathing, Shallow breathing, Shortness of breath, Recurrent/chronic cough, Coughing up blood, Coughing up phlegm, Asthma/wheezing, Production of phlegm, High blood pressure, Low blood pressure, Heart palpitations or rapid heartbeat, Irregular heartbeat, Other _____

Digestion (Circle): Little appetite, Strong appetite, Hunger but no desire to eat, Food cravings, Belching, Nausea, Vomiting, Heartburn, Indigestion, Abdominal pain, Weight loss, Weight gain, Loose stools/diarrhea, Dysentery, Strong smelling stools, Blood in stools, Constipation (< 1 b.m./day), dry stools, difficulty, Alternating constipation and diarrhea, Gas/flatulence, Hernia, Rectal pain/prolapse, Hemorrhoids, Anorexia nervosa, Bulimia, Bad breath, Other _____

Urinary (Circle): Pain on urination, Urgent urination, Frequent urination, Blood in urine, Cloudy urine, Dribbling urination, Urinary incontinence/retention, Incontinence at night, Do you wake to urinate? How many times? _____, Bladder/kidney infections, Recurrent yeast infections, Kidney stones, Other _____

Male System (Circle): Prostate problems, Change in sexual drive, Rashes/itching, Genital discharge, Erection difficulty, Low sperm count/motility, Other _____

Female System (Circle): Premenstrual irritability, Clots in menstrual blood, Missed menses, Spotting/abnormal bleeding, Vaginal discharge, Vaginal dryness, Vaginal dryness, Genital sores, Ovarian cysts, Fibroids, Endometriosis, Breast lumps, Breast swelling or redness, Nipple discharge, Abnormal Pap smear, Infertility, Are you pregnant now?

Is it possible you're pregnant now? _____, Are you trying to get pregnant? _____, Do you practice birth control? What type and for how long? _____, Number of pregnancies _____, Number of Births _____, Num. of premature births _____, Number of abortions _____, Age of first menses _____, Duration of menses _____, First day of last menses, Number of days in cycle _____, Age of Menopause _____, Date of last Pap _____, Other _____

Muscles and Joints (Circle): Neck pain, Shoulder pain, Back pain – Where _____, Hand/wrist pain, Knee pain, Foot/ankle pain, Joint/bone problems, Muscle pain/weakness, Tremors/tics in muscles, Osteoporosis, Herniated disc, Sciatica, Other _____

Mind and Emotions (Circle): Poor memory, Difficulty concentrating, Depression, Often stressed, Lose control of emotions, Substance abuse, Anxiety/nervousness, Manic behavior, Panic attacks, Easily angered, Aggressive behavior, Other _____

Daily Routines

Please describe your daily activities from when you awake until you go to sleep. Include types of food you eat, exercise, work and other activities.

	Time	Activities, Foods, Routine	Variation
Morning			
Awaken	_____	_____	_____
Breakfast	_____	_____	_____
Activities after breakfast	_____	_____	_____

	Time	Activities, Foods, Routine	Variation
Midday			
Lunch	_____	_____	_____
Activities after lunch	_____	_____	_____
Evening			
Dinner	_____	_____	_____
Activities after dinner	_____	_____	_____
Night			
Activities	_____	_____	_____
Bed time	_____	_____	_____

List other regular activities not included above. These could be exercise, meditation, spiritual practices, etc. _____

Are you sexually active? Yes _____ No _____ Frequency _____

How many hours per week do you work? _____ Do you enjoy what you do? _____

How far is your commute? _____

How many hours a day do you spend sitting or driving? _____

Other comments about your daily routine _____

General Health Habits

Are you a vegetarian or vegan? Yes _____ No _____ If yes, how long _____

What are the major stressors in your life? _____

How much water do you drink per day? Number of cups _____

Do you exercise regularly? Yes _____ No _____ Length of time _____ Times per week _____
 Types(s) of exercise _____

Please mark any of the following that apply.

Aspirin	currently _____	occasionally _____	Diet pills	currently _____	occasionally _____
Tranquilizers	currently _____	occasionally _____	Vitamins	currently _____	occasionally _____
Antacids	currently _____	occasionally _____	Sleeping pills	currently _____	occasionally _____
Laxatives	currently _____	occasionally _____	Herbs	currently _____	occasionally _____
Cold tablets	currently _____	occasionally _____	Antihistamines	currently _____	occasionally _____
Ibuprofen	currently _____	occasionally _____	Oral contraceptives	currently _____	occasionally _____

List any medications, vitamins and or supplements you are currently taking _____

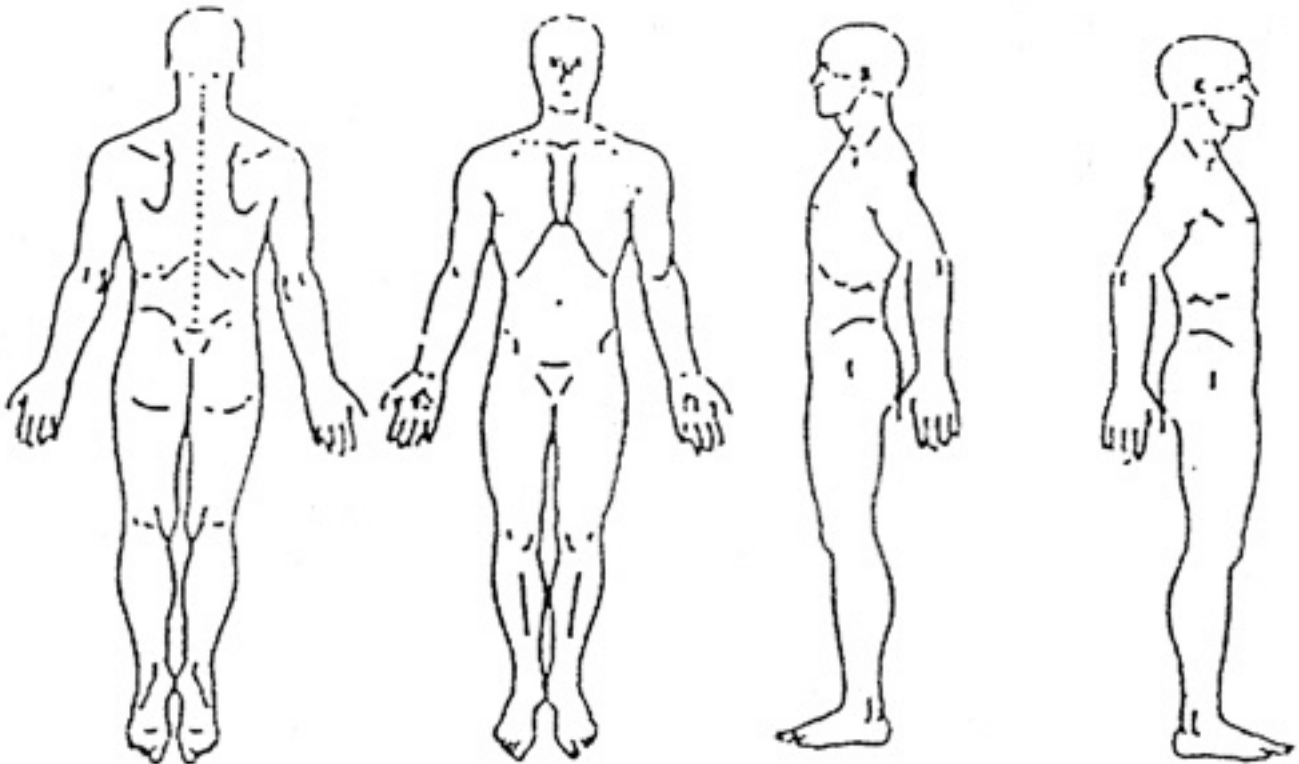
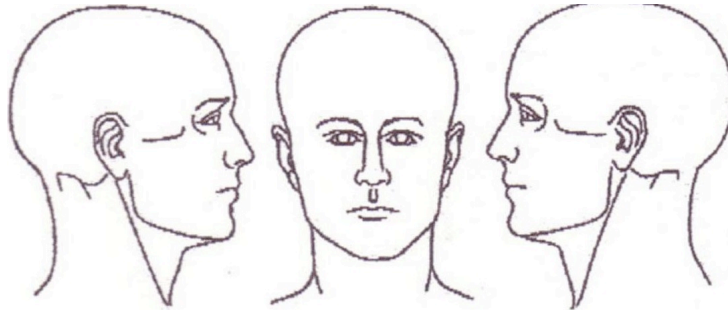
Please mark your current use levels of the following:

Tobacco	frequently_____	occasionally_____	never_____	Number of cigarettes per day_____	Age started _____
Alcohol	frequently_____	occasionally_____	never_____	Number of drinks per week_____	Type of drinks _____
Caffeine	frequently_____	occasionally_____	never_____	Number of cups per day_____	Type of drinks _____
Marijuana	frequently_____	occasionally_____	never_____	Number of times per week _____	
Ecstasy	frequently_____	occasionally_____	never_____	Number of times per month _____	
Cocaine	frequently_____	occasionally_____	never_____	Number of times per month _____	
Other	frequently_____	occasionally_____	never_____	Describe _____	

Do you have any current or past problems with addiction or substance abuse? Yes _____ No _____

Substance _____ Amount _____ When did you quit? _____

Please indicate areas of pain or distress:



Signature _____ Date _____