



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. Also indicate if any apply to a family member.

- | | | |
|--|--|--|
| <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 _____

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

Have you undergone a course of antibiotics lately? _____

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: _____

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: _____

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

Activities, Foods, Routine

Morning _____

Afternoon _____

Evening _____

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/length of your commute? Drive? _____

General Health Habits

Describe diet: _____ 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 _____

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 _____

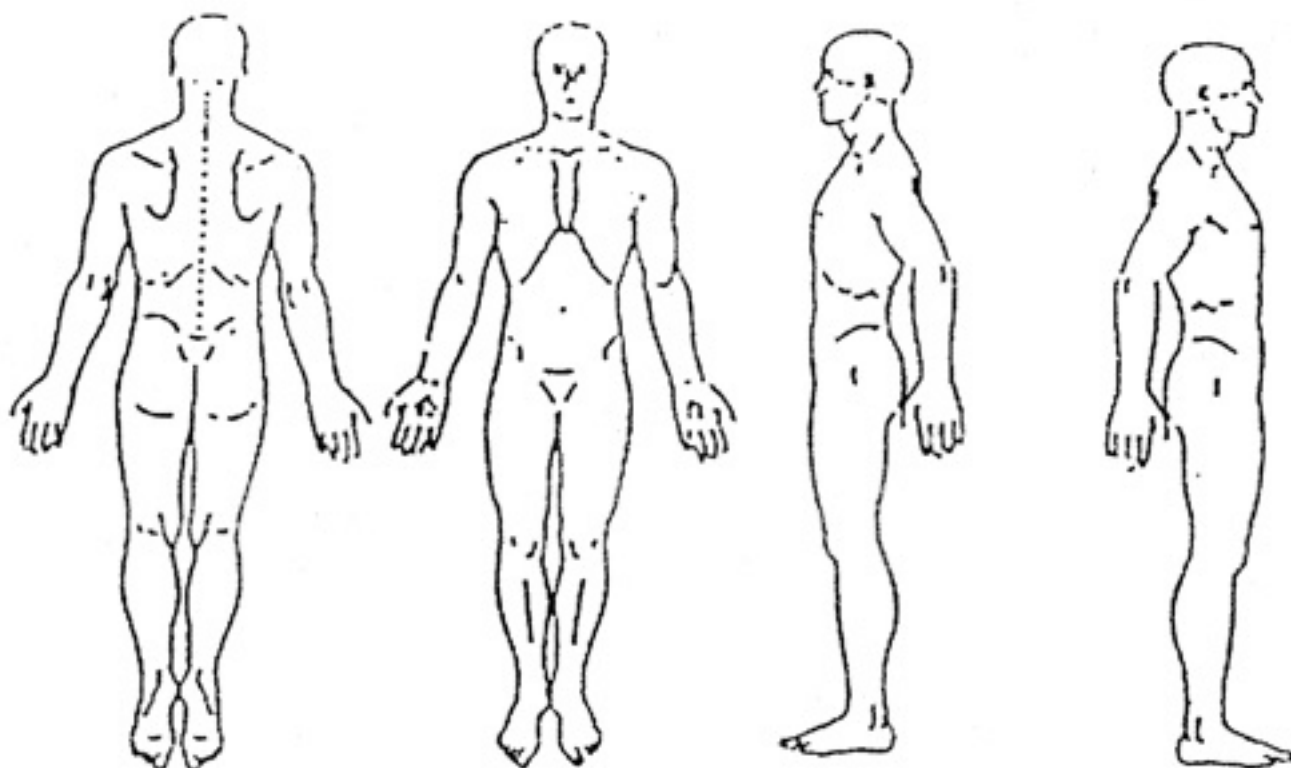
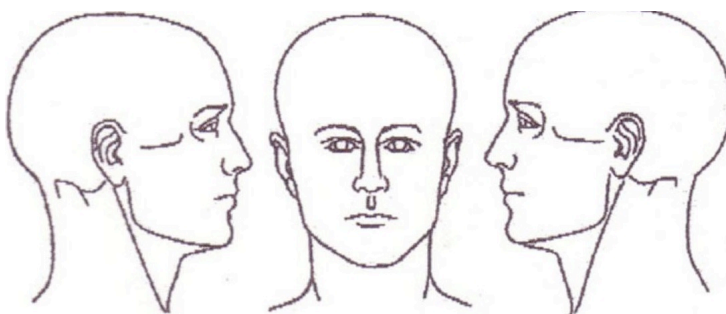
Cocaine frequently _____ occasionally _____ never _____ Number of times per month _____

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 _____