Confluence & Healing

Scott Towne Center ~ 2101 Greentree Road, Suite A-204, Pittsburgh, PA 15220 ~ [412] 279 – 1115 / www.confluencehealing.com

Patient Identification / Contact Information: At times it may be necessary to communicate to you regarding your appointments, matters relating to your care, or to provide you valuable promotional or event notices.

May we contact you by phone or email regarding appointments or matters pertaining to your care? Yes___ No ___

Are you interested in receiving promotional or event notices? Yes ___ No ___

Name_____Date_____

Home Address _____

City_____ State_____ Zip _____ E- Mail _____

Home Phone _____ Cell Phone _____

Work Phone _____ext. _____ Occupation_____

Emergency Contact (EC)_____ Relationship _____

(EC) Home Phone: _____ (EC) Cell Phone:_____ (EC) Work: _____

(From the above, please leave the best daytime number to reach this person, they will only be contacted in an emergency)

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered

Your Date of Birth _____ Your Age _____

Have you had acupuncture before? ❑ Yes ❑ No How did you hear about us? _____

Medical Survey

Please state briefly, the primary reason you are seeking treatment today. _____

_____

_____

_____

What other forms of treatment have you sought?

_____

_____

_____

_____

When was the onset of your primary medical concern?

_____

_____

_____

Have you seen a Medical Doctor concerning your condition, and if yes, when?

_____

_____

_____

If your primary concern is an injury, how did this occur?

_____

_____

_____

_____

Medical Diagnosis, if provided by an M.D.

_____

_____

_____

List any Accidents, Surgeries, or Hospitalizations. Please include reason and approximate dates if known.

_____ _____

_____ _____

_____ _____

_____ _____

Check any boxes that may apply:

- ❑ I have a pacemaker
- ❑ I have a bleeding disorder or use blood thinners
- ❑ Current or active infectious disease
- ❑ Recent or current MRSA infection
- ❑ My immune system is compromised
- ❑ I currently have suicidal thoughts
- ❑ History of sexual, mental, or physical abuse

Do you have any allergies to medications, chemicals or foods? Please list _____

_____

_____

List any current medications or supplements:

_____

_____

_____

_____

Do you exercise regularly? ❑ Yes ❑ No If so, what kind and how often?_____

_____

Hobbies /Leisure Activities/Sports_____

Height_____ Present Weight_____ Ideal Weight _____

Any recent weight loss or weight gain? Amount of Loss?_____ Amount of gain? _____

Please indicate by checking any boxes that apply to you or your blood relative [Grandparent, parent, or sibling]

	You	Relative		You	Relative
Asthma / Allergies	❑	❑	Kidney Disease	❑	❑
Infectious Disease	❑	❑	Diabetes	❑	❑
Migraines	❑	❑	Cancer	❑	❑
High Blood Pressure	❑	❑	Anemia /Blood disorder	❑	❑
Heart Attack / Stroke	❑	❑	Autoimmune Disease	❑	❑
Heart Disease	❑	❑	Osteoporosis	❑	❑
High Cholesterol	❑	❑	Arthritis	❑	❑
Pulmonary Disease	❑	❑	Epilepsy / Seizures	❑	❑
Tuberculosis	❑	❑	Mental Illness	❑	❑
Hepatitis	❑	❑	Eating Disorders	❑	❑
Thyroid Disease	❑	❑	Emotional Disorders	❑	❑

Please list any Medical Conditions you may have that are not previously listed: _____

_____

_____

Review of Mind / Body Symptoms

Regarding this next section: Please indicate by checking next to any symptom you regularly experience, or have experienced in the last two weeks. You may also **circle** any symptoms which are particularly troublesome. Symptoms may appear more than once, so check for each time they appear.

___ Poor or variable appetite
___ Hard to gain, lose, or regulate weight
___ Tiredness / fatigue /lethargy
___ Abdominal distention or bloating after meals
___ Excessive gas
___ Worry, over-think, or obsess
___ Difficult to focus, poor memory
___ Cravings for sweets
___ Lack of muscle tone or strength
___ Tip of nose often feels cold
___ Easily bruises
___ Feeling cold easily
___ Diarrhea w/ partially digested food

___ Asthma or wheezing
___ Low, soft voice
___ Weak voice
___ Shortness of breath
___ Perspires VERY easily or for no reason, spontaneously
___ Frequent colds, allergies
___ Weak cough
___ Watery nasal discharge
___ Prolonged feelings of grief or sadness

___ Prolapse of organs
___ Hemorrhoids
___ Vericose veins
___ "Bearing down" or sinking feeling in lower abdomen

___ Water retention or swelling of legs/ankles, abdomen
___ Puffy eyes, face or hands
___ Feelings of heaviness in body, limbs, or head
___ Excessive saliva, drools easily
___ Lack of thirst or thirst but no desire to drink fluids
___ Nausea or vomiting
___ Soft, unformed, or loose stools
___ Loose stools with offensive odor
___ Burning sensation with bowel movements
___ Scanty, frequent urine
___ Mental fog
___ Sweetish taste in mouth
___ Headaches like a tight band around the head
___ Weeping skin lesions
___ Lethargic in humid weather

___ Wheezing
___ Barking cough
___ Sticky, thick mucus
___ Yellow, green, or brown mucus or foul smelling discharges
___ Copious clear or white mucus
___ Mucus worse in the A.M.
___ Frequent nasal congestion
___ Internal nodules or cysts
___ External nodules or cysts
___ Nausea or vomiting
___ Severe Vertigo, room spinning
___ Feel worse when eating greasy, oily foods, dairy, sugar

___ Pain or full feeling in the ribs
___ Feeling like it is hard to take in a full or satisfying breath
___ Cold fingertips or toes
___ Frequent sighing
___ Frequent belching
___ Feeling like a lump in throat or difficulty in swallowing
___ Depression or moodiness
___ Easily frustrated or quick to anger
___ Irritability
___ Pebble like stools
___ Constipation
___ Alternating constipation or diarrhea
___ Gas pains, cramps, tension in stomach or abdomen
___ Sensitive stomach or intestinal problems related to stress
___ Acid reflux or indigestion
___ Irregular menstrual periods
___ PMS, breast swelling, tenderness

___ Severe menstrual cramps with dark blood or blood clots
___ Mottling, numbing , or chilling of hands, feet, or limbs
___ Poor circulation
___ Angina or diagnosed heart disease
___ Fixed, stabbing like pain on any part of the body
___ Painful hemorrhoids, cysts, lumps
___ Pain aggravated at night or from Inactivity
___ Purplish lesions or areas on body

___ Intense thirst for cold water
___ Red face, ears
___ Red, burning eyes
___ High pitched ringing in ears
___ Intense headaches
___ Dark yellow urine
___ Burning sensation with urination
___ Bitter taste in mouth

___ Mouth or tongue ulcers
___ Restless dream disturbed sleep or nightmares
___ Easily agitated, quick to anger
___ Easily overheated or easily sweats

___ Constipation w/ very dry stools
___ Bleeding or painful gums
___ Constant hunger & appetite
___ Acid reflux or bitter regurgitation

___ Feeling "feverish" that's worse in afternoon or evening
___ Heat sensations in the palms or soles of the feet
___ Menopausal "hot flashes" or night-sweats
___ Thirst, especially at night
___ Vaginal dryness
___ Low back pain or weakness
___ Tendency for knee or foot weakness, pain, or injury
___ Hair loss or early graying
___ Fertility problems
___ Early menopause

___ Loosening or loss of teeth
___ Decline of memory, vision, or hearing
___ Congenital problem with bones
___ Emaciation or atrophy of tissues

___ Sudden Vertigo or dizziness
___ Migraines or intense pounding headaches
___ High pitched ringing in ears
___ Hypertension
___ Blurry vision
___ Tendency for angry outbursts

___ Seizures, stroke or T.I.A.'s
___ Feeling agitated or worse in windy, fast changing weather
___ Tremors of hands, feet, or head
___ Disequilibrium, incoordination
___ Spasms, ticks, twitches, cramps, of nerves or muscles

___ Anemia
___ Poor skin healing
___ Vague, or mild dizziness
___ Thinning of hair
___ Forgetfulness, poor memory
___ Mild numbness or tingling in limbs
___ Pale complexion, lips, nails
___ Dry skin, hair, eyes
___ Dull headache
___ Muscle cramps

___ Poor night vision," floaters" in vision
___ Scanty or infrequent menstruation
___ Brittle or thin weak nails
___ Very dry, straw-like hair
___ Tight, contracted muscles, esp. of the shoulders, head, neck, or jaw

___ Insomnia and/ or anxious sleep
___ Heart palpitations or fluttering
___ Cold hands
___ Restless Fatigue
___ Anxiety or dread
___ Easily startled and jumpy

___ Acute abdominal pain or diarrhea brought on by cold foods or drink
___ Stomach ache relieved by heat
___ Palpable cold areas on the body
___ Craving for warm, cooked foods and hot drinks
___ Body or joint pain aggravated by cold temperatures
___ Groin pain or history of hernia
___ Pale, purplish skin, nail beds, lips or tongue

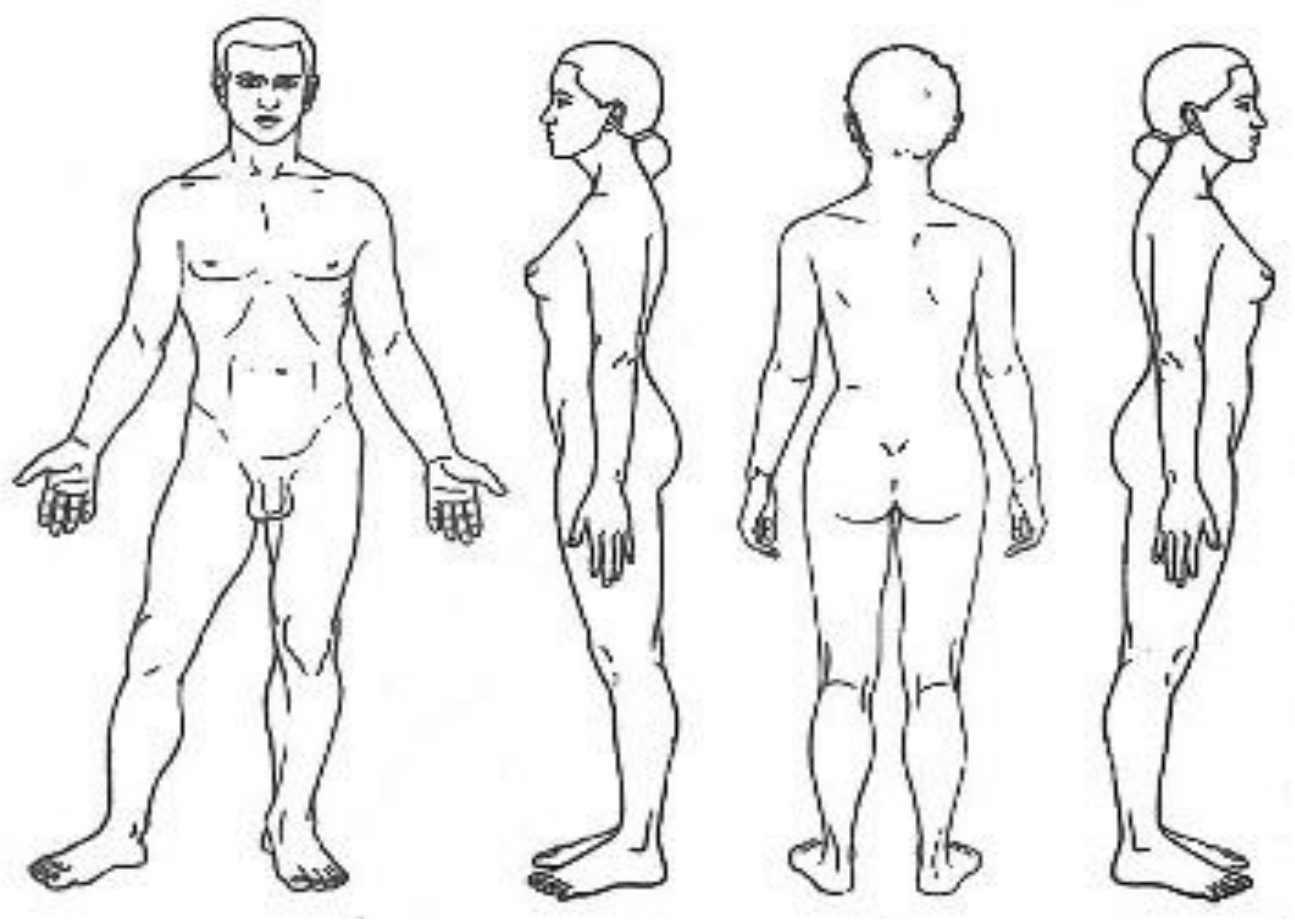
___ Fever or chills
___ Sweating associated w/ cold or flu symptoms
___Body aches associated w/ cold or flu
___ Sore, scratchy throat
___ Swollen glands
___ Sinus or ear pain
___ Nasal congestion or runny nose
___ Cough with chest congestion
___ Dry, barking cough

___ Puffiness around eyes, dark circles
___ Profound exhaustion or lack of stamina and endurance
___ Low back pain, or soreness
___ Weakness of back, feet or knees
___ Cold feeling in back, buttocks, hips, belly, or limbs
___ Diminished libido
___ Diminished motivation, apathy
___ Puffiness/swelling of ankles/feet
___ Tendency to be overweight
___ Cravings for salt
___ Low humming or buzzing in ears
___ Disorders of urination
___ Frequent night-time urination
___ Diarrhea before daybreak

Body Pain Chart

Please indicate by placing: XXX's in any areas you experience pain and / or 000's in any areas you experience numbness or tingling.

Left Right



For Women

Age of first period_____ Start date of last period _____/_____/_____ Age of menopause _____

Number of days in cycle (ex.28, 30)_____ #of days blood flow _____Color of flow _____

Is your cycle regular? ❑ Yes ❑ No Do you experience PMS? ❑ Yes ❑ No Is your period painful? ❑ Yes ❑ No

Clots in flow? ❑ Yes ❑ No Do you experience "spotting" w/ menses? ❑ Yes ❑ No (If yes, circle: before, after or midcycle)

Check any that apply: ❑ Fibroids ❑ PID ❑ Endometriosis ❑ Ovarian Cysts ❑ Fibrocystic breasts ❑ Breast cancer

Are you pregnant? ❑ Yes ❑ No Number of live births _____ Any miscarriages ? _____