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.

- ☐ Allergies ______________________
- ☐ Asthma _______________________
- ☐ Cancer _______________________
- ☐ Diabetes ______________________
- ☐ Heart disease _________________
- ☐ Hepatitis ______________________
- ☐ High blood pressure ____________
- ☐ HIV/AIDS ______________________
- ☐ Seizures ______________________
- ☐ Stroke ________________________
- ☐ Thyroid disease ________________
- ☐ 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 * **Select and Highlight Symptoms, then Save the File as Your First and Last Name**

General: 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: 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: 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: Loss of taste/smell/touch, Tingling sensations/numbness, Tremors - Where?___________, Lack of coordination/balance, Paralysis or seizures, Stroke, Concussion, Other ____

Digestion: 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: 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: Prostate problems, Change in sexual drive, Rashes/itching, Genital discharge, Erection difficulty, Low sperm count/motility, Other ____

Female System: 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: 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: 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 ____

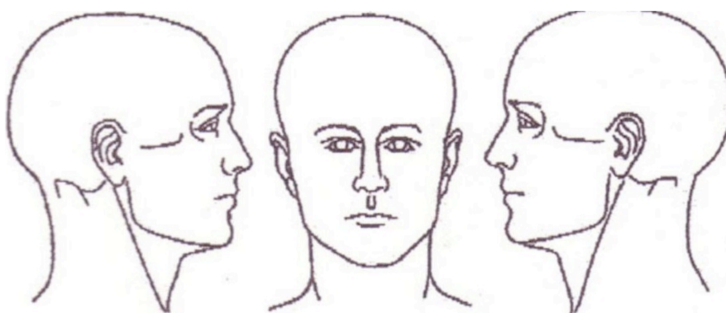
List any medications, vitamins and or supplements you are currently taking ____
____

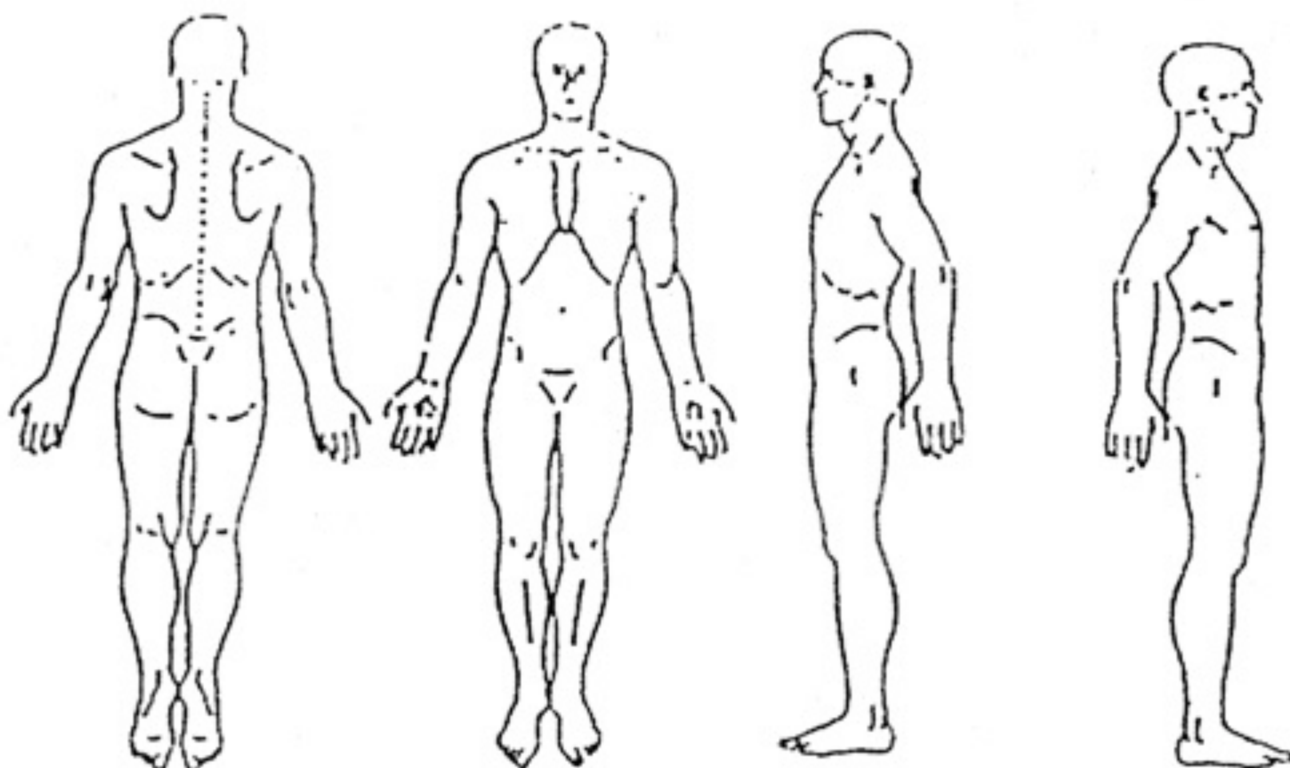
Please mark your current use levels of the following:

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:	Enter an X on the figure below to indicate





Signature____ **Date** _____________________