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 _____ ☐ Heart disease _____ ☐ Seizures _____
☐ Asthma _____ ☐ Hepatitis _____ ☐ Stroke _____
☐ Cancer _____ ☐ High blood pressure _____ ☐ Thyroid disease _____
☐ Diabetes _____ ☐ HIV/AIDS _____ ☐ 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 spermcount/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? Change in Sexual Drive? 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_____
_____
_____
_____

Non-Binary: Pronouns:_____
_____
_____

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 _____

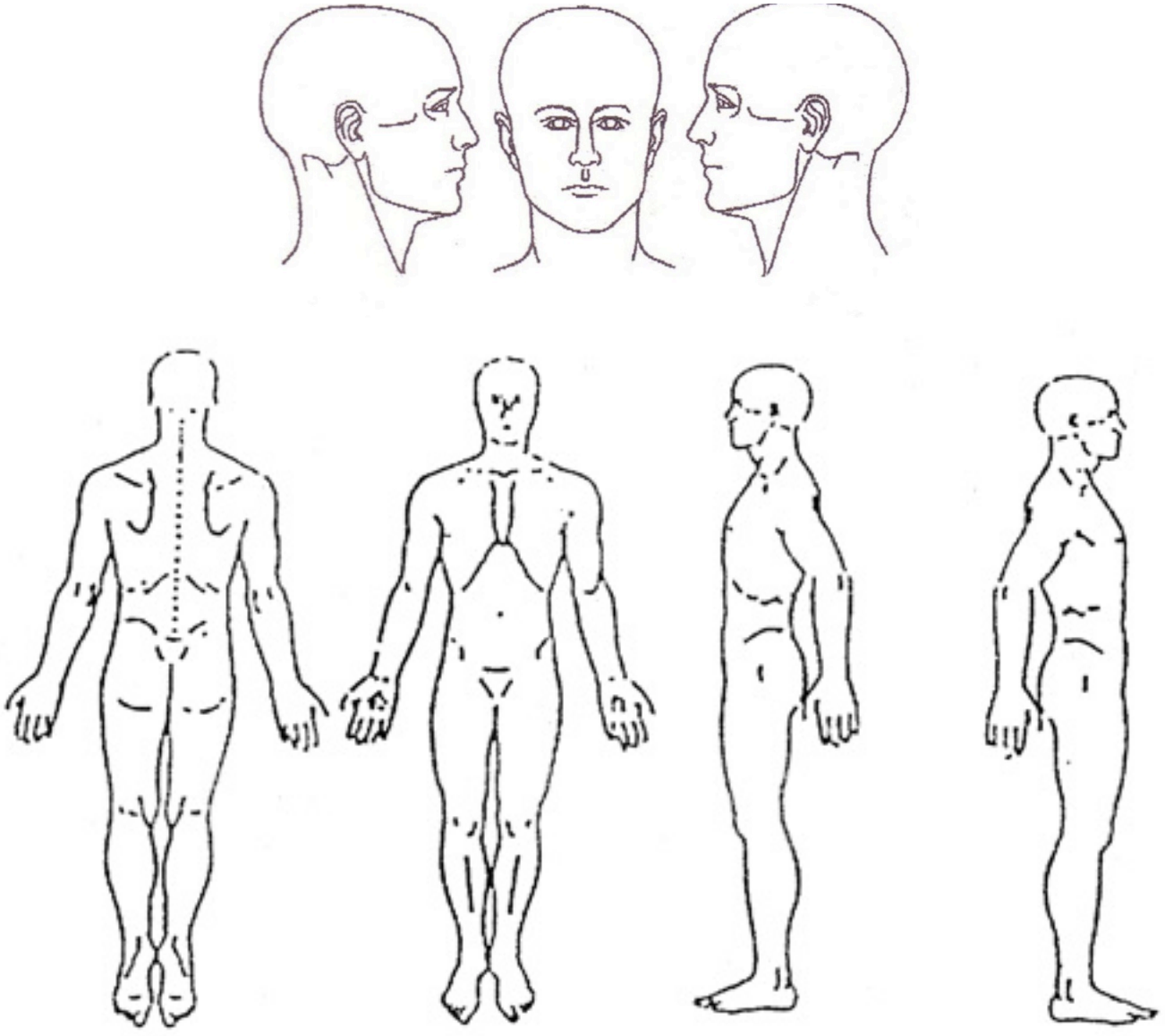
List any medications, vitamins and or supplements you are currently taking _____
_____
_____

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** _____