FullCircle Acupuncture HealthCentre

Date_____/_____/_____

New Patient Profile

Please fill this form accurately. Success of treatment depends on the truthfulness of your answers. This is strictly confidential.

Name_____Gender M F
Address, City, State, Zip_____
E-mail_____
Cell Phone_____ Work _____ Home_____
Date of Birth____/____/_____ Age____ Occupation _____
Emergency Contact: Relationship and Phone _____
Primary Care Physician: Name and Phone _____
May we contact your physician? N Y Date of last physical____/____/_____ Were all tests negative? N Y If not, what came positive? Please use the last page of this form to elaborate. Use this➔ number (1) to cite this item answer_____

_____

Have you ever had Acupuncture?_____

INSURANCE INFORMATION

As the policy of insurance companies in relation to Complementary Medicine healthcare providers stands today in the United States, **FullCircle Acupuncture HealthCentre** provides you with a hard copy of the receipt of payment at the time of service that you may claim direct payment from the insurance company to you.

PRIMARY COMPLAINTS / DATES AND CAUSES OF ORIGIN / WHAT MAKES IT BETTER (2)

1_____
_____
_____
2_____
_____
_____

Were you diagnosed by your primary care physician (3) N Y When? ___/___/_____
If in pain, on a scale of 1 to 10, where 1 is least, what is your level of pain now? _____
Besides your primary care physician and seeking Acupuncture treatment, what other remedies have you sought? _____When? ____/____/_____

CURRENT MEDICATIONS (4)	**CURRENT SUPPLEMENTS (4)**	DOSES / TIMES PER DAY (4)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY

Please check all that apply to Mother (M), Father (F), Brother (B), Sister (S), and myself (MS)

Arthritis _____ Alcoholism_____ Alzheimer's_____
Anemia_____ Asthma_____ Anxiety _____
ALS_____ Bipolar _____ Cancer _____
Crohn's Disease ___ _____ Depression_____ Diabetes I, II _____
Drug Addiction _____ Epilepsy_____ Fibromyalgia_____
Fainting Spells _____ Filariasis _____ Hair Loss_____
Heart Disease _____ Heartburn_____ Hypertension_____
Impotence_____ Migraine _____ MSclerosis_____
IBS_____ Lyme Disease _____ Mental Illness _____
Parkinson's _____ Prostate Issues_____ Pneumonia_____
Lupus SLE_____ Sleep Apnea _____ Seizures_____
Stress _____ Stroke _____ Suicide_____
Thyroid _____ Pulmonary Hypertension _____
Other_____

YOUR MEDICAL HISTORY

Please check all that apply and include dates where necessary

Do you have or have had any of the following? Please circle

Hepatitis B or C HIV/AIDS Herpes I, II Tuberculosis

Do you get cold sores in/or around your mouth or face? N Y How often?_____
Do you have pets? Dog Cat Bird Rodent Reptile Other _____
Have you had surgery, hospitalization or trauma (accident, falls, emotional, sexual) (5) N Y
Do you have allergies: food, drugs, chemicals, etc. _____
Do you have a pacemaker? N Y Do you have metal plates, rods or implants? N Y
If so please list _____

Ears/Nose/Throat/Mouth/Head

○ Ringing in the ears ○ Dry Mouth ○ Taste in Mouth ○ Teeth Grinding
○ Sores mouth/tongue ○ Bleeding Gums ○ Sore Throat ○ Earaches
○ Loss of Balance ○ Caries ○ Nose bleeds ○ TMJ
○ Eye Pain/Strain ○ Blurry Vision ○ Dry Eyes ○ Headaches
○ Sinus Problems ○ Redness ○ Twitch ○ Floaters
○ Sensation of something stuck in the throat ○ Night Blindness ○ Hearing Loss

Gastrointestinal-Stomach/Large Intestine/Small Intestine

○ Indigestion ○ Belching ○ Nausea/Vomiting ○ Heartburn
○ IBS ○ Ulcers ○ Gas/Bloating ○ Poor Appetite
○ Voracious Appetite ○ Cravings ○ Bad Breath ○ Constipation
○ Crohn's Disease ○ Hemorrhoids ○ Blood in Stools ○ Diarrhea
○ Abdominal Pain/Cramps ○ Black Stools ○ Other_____

Genitourinary-Kidney/Urinary Bladder

○ Frequent Urination ○ Painful Urination ○ Edema/Swelling ○ Decreased Libido
○ Dribbling ○ Blood in Urine ○ Genital Pain ○ Burning
○ Genital Itching ○ No energy or long sleep after sex ○ Premature Ejaculation
○ Erectile Dysfunction ○ If night Urination, how many times ____ ○ Hair Loss
○ Change Skin Texture ○ Night Sweats ○ Hearing Loss ○ Sudden Energy Drop
○ Premature Graying ○ Nocturnal Emissions ○ Frequent Seminal Emissions
○ Swollen Testicles ○ STD ○ Penile Discharge ○ Kidney Stones
○ Inability to Hold Urine ○ Other _____

Circulation-Heart

○ Cold hands/feet ○ Blood Clots ○ Palpitations/Flutters ○ Chest Pain
○ Hot/Cold Intolerance ○ Bruises Easily ○ Varicose Veins ○ Lightheadedness
○ Dental Health N Y ○ Fainting ○ Heart Murmurs ○ Irregular Beat
○ HighBloodPressure ○ Unusual Sweating ○ Insomnia

Respiratory-Skin/Lung

○ Shortness of Breath ○ Wheezing ○ Chest Oppression ○ Dandruff
○ Repeated Cold or Flu ○ Eczema ○ Emphysema ○ Asthma
○ Difficulty Breathing ○ Allergies ○ Bronchitis ○ Pleurisy
○ Coughing up Phlegm and/or Blood ○ Persistent Cough ○ Dry Skin
○ Itching ○ Psoriasis ○ Rashes ○ Recent Moles ○ Hives

Musculoskeletal-Frame/Marrow/Spleen

○ Upper/Mid/Low Back Pain ○ Joint Pain or Swelling ○ Leg/Knee Pain ○ Hip Pain
○ Neck/Shoulder Pain ○ Carpal Tunnel ○ Foot Pain ○ Sciatica

Neuro-Psychological-Liver

○ Vertigo/Dizziness ○ Numbness/Tingling ○ Difficulty Concentrating ○ Stress
○ Poor Balance ○ Poor Memory ○ Finger Twitches ○Anxiety
○ Tremors ○ Confusion ○ Seizures ○ Bipolar
○ Bad/Quick Temper/Irritability ○ Tourette ○ Other _____

Lifestyle and Self Care

Do you smoke cigarettes? N Y How many?_____ How long?_____
Do you use recreational drugs? N Y Which _____
_____ How long? _____
Do you drink alcohol? N Y
Drink daily? Weekly? Occasionally?(circle) What and how many drinks? _____
After 3 drinks, do you get drunk or tipsy? N Y How often? _____
Do friends/family tell you should stop? If not, do **you** think you need to stop? N Y

Do you have sex? N Y If no, why not? (6) _____If yes, how often and with one or multiple partners? (6) _____
Do you enjoy your job? N Y If no, what would you rather do? _____
Do you have friends? N Y If no, would you like to? Or do you care? (7) N Y
Do you cultivate a spiritual life? N Y If yes, what do you do? _____
Do you meditate? N Y If yes, what do you do? _____
Do you exercise and/or do yoga? N Y If yes, how often? _____

Social History Please check all that apply
Major Stresses in the past 6 months: N Y ○ Marriage ○Separation ○Divorce
○ Job ○ New Relationship ○ Other _____
Marital Status: ○ Single ○ Live-With ○ Married ○ Divorced ○ Widowed
Do you have children? N Y How many? _____ Ages? _____
Living Arrangement: ○ Alone ○ Roommate ○ Family
How do you see your life? ○ O.K. ○ Satisfactory ○ Good ○ Stressful
○ Too demanding ○ Unsatisfactory ○ Don't Know

Diet

○ Omnivore ○ Vegetarian ○ Vegan ○ Eat lots of fast foods
○ Balanced diet ○ Whatever available ○ Special diet_____
Do you drink coffee and sodas? N Y What? _____How much of it?_____
Do you use artificial sweeteners? N Y What?_____
Do you eat spicy hot foods? N Y _____
Do you eat raw foods often? N Y _____
Do you eat rich grease foods often? N Y _____
How often do you eat sweets? Never Often Occasionally
Do you crave certain foods? N Y What? _____

Average daily menu

Breakfast_____
Lunch _____
Dinner_____
Snacks_____

Are you bipolar? N Y Are you under the care of a psychiatrist? N Y
Are you currently doing talk-therapy with a psychotherapist? N Y
May we contact your physicians? N Y Please include names, phone# and trade

_____
_____
_____
_____

1. If you wish to change an appointment, please give 24 hours advanced notice.
2. Herbal formulas are intended **only** for whom they are prescribed. Sales are final.

Signature_____**Date**____/____/_____

If needed use this space to amplify your answers from above. Use the numbers in parenthesis to cite the answer you are referring to. **(1) (2) (3) (4) (5) (6) (7)**