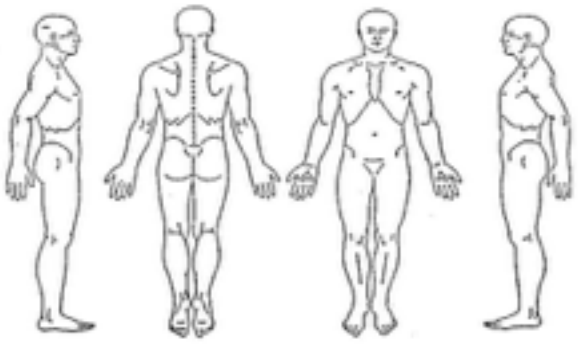
THE COMMUNITY ACUPUNCTURE CENTER OF EASTHAMPTON

Patient Information	Contact Information
Name:_____ Today's Date:_____ Address:_____ City:_____ State:_____ Zip:_____ Age:_____ Date of Birth:_____ Occupation:_____ Male/Female/Transgender/Other:_____ Primary Care Provider:_____	Phone Number:_____ Email:_____ Opt in to monthly newsletter? Yes or No Emergency Contact: Name:_____ Relationship:_____ Phone Number:_____ How did you hear about us?_____
Main Complaint	**Medical History**
1)_____ When did this start?_____ Frequency?:_____ Severity?: (1 = minor / 10 = severe) Please circle. 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 2)_____ When did this start?_____ Frequency?:_____ Severity?: (1 = minor / 10 = severe) Please circle. 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 3)_____ When did this start?_____ Frequency?:_____ Severity?: (1 = minor / 10 = severe) Please circle. 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10	☐ Anemia ☐ Bleeding Disorders ☐ Cancer ☐ Diabetes ☐ Dizziness / Lightheadedness ☐ Fainting ☐ Heart Disease ☐ Hepatitis ☐ HIV/AIDS ☐ High Blood Pressure ☐ Heart Disease ☐Pacemaker ☐ Seizures/Epilepsy ☐ Stroke ☐ Thyroid Disease ☐ Allergies ☐ Depression ☐ Anxiety ☐ **Are you pregnant or trying to get pregnant?** ☐Yes ☐No (Please let me know if at any point you may be pregnant or are trying to get pregnant.) ☐ **Are you taking blood thinners or any anti coagulant medications?** ☐ Yes ☐ No List all medications, herbs and supplements: _____ _____ _____
Past Medical History	Please circle any areas of the body that are painful or troublesome:
☐Hospitalizations/Surgeries:_____ _____ ☐Significant Trauma (auto accidents, falls, injuries, etc):_____ _____ ☐Allergies (drugs, chemicals, metals, foods, etc): _____ _____ ☐Do you have a regular exercise program	

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General Health	Hair and Skin
☐ Body Temperature: Warm / Cool / Neutral ☐ Sweat Easily ☐ Night Sweats ☐ Recent unexplained weight loss ☐ Weight Gain ☐ Change in Appetite ☐ Strong Thirst ☐ Bruise Easily ☐ Low Energy	☐ Eczema ☐ Hives ☐ Itching ☐ Pimples ☐ Dandruff ☐ Psoriasis ☐ Dermatitis ☐ Acne ☐ Rashes ☐ Ulcerations ☐ Loss of Hair ☐ Recent Moles ☐ Change in Hair or Skin Texture ☐ Other:_____
Eyes, Ears, Nose, Throat & Head	**Heart & Lung**
☐ Dizziness ☐ Concussion ☐ Migraine ☐ Glasses ☐ Eye Strain ☐ Eye Pain ☐ Poor Vision ☐ Cataracts ☐ Night Blindness ☐ Color Blindness ☐ Headache ☐ Earache ☐ Ringing in Ears ☐ Spots in Eyes ☐ Poor Hearing ☐ Sinus Problems ☐ Nose Bleeds ☐ Grinding Teeth ☐ Clenching Jaw ☐ Facial Pain ☐ Other:_____	☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Pain ☐ Fainting ☐ Blood Clots ☐ Palpitations ☐ Swelling of Hands or Feet ☐ Varicose or Spider Veins ☐ Cough ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Chest Tightness ☐ Seasonal Allergies ☐ Cold Hands or Feet ☐ Other:_____
Gastrointestinal	**Genito-Urinary**
☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas ☐ Belching ☐ Blood in Stool ☐ Indigestion ☐ Bad Breath ☐ Hemorrhoids ☐ Bleeding Gums ☐ Bloating/Edema ☐ Acid Reflux/GERD ☐ Hernia ☐ Excessive Appetite ☐ Poor Appetite ☐ Colitis ☐ IBS/Crohn's Disease ☐ Abdominal Pain/Cramps ☐ Other:_____	☐ Frequent Urination ☐ Urgency to Urinate ☐ Unable to hold urine ☐ Blood in Urine ☐ Painful Urination ☐ Decrease in Flow ☐ Kidney Stones ☐ Impotency ☐ Sores on Genitals ☐ Cloudy Urine ☐ Night time Urination? How many times? _____ ☐ Other:_____
Reproductive & Gynecological	**Musculoskeletal**
☐ Irregular Periods ☐ Painful Periods ☐ PMS ☐ Clots ☐ Endometriosis ☐ PCOS ☐ Fibroids ☐ Ovarian Cysts ☐ Vaginal Dryness ☐ Heavy Period ☐ Light Period ☐ Regular Period ☐ Breast Lumps ☐ Fibrocystic Breast Tissue ☐ Hot Flashes ☐ Menopausal Symptoms ☐ **Pregnancy:** Number of Pregnancies:_____ Live Births:_____ Miscarriage:____ Abortion:_____ Complications?_____ ☐ **Last Menstrual Period:**_____ ☐ **Time Between Periods:**_____ ☐ **Duration of Menses:**_____	☐ **Any pain in the following:** ☐ Rotator Cuff ☐ Knee ☐ Foot ☐ Ankle ☐ Muscle ☐ Shoulder ☐ Back (Upper / Middle/ Low) ☐ Neck ☐ Hip ☐ Hand ☐ Wrist ☐ Other:_____ ☐ Carpal Tunnel ☐ Tendonitis ☐ Bursitis ☐ Muscle Spasm ☐ Muscle Weakness ☐ Muscle Tightness ☐ Sprain/Strain ☐ Other:_____
Neurological,Psychological & Emotional	
☐ Seizures ☐ Dizziness ☐ Loss of Balance ☐ Poor Coordination ☐ Bad Temper ☐ Anxiety ☐ Depression ☐ Easily Susceptible to Stress	☐ Nervousness ☐ Worry ☐ Racing Thoughts ☐ Insomnia ☐ Difficulty Staying Asleep ☐ ADD/ADHD ☐ Bipolar ☐ Grief/Sadness