Sarah Coles McKeown, L.Ac.
19 west 21st street, suite 904
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PATIENT INFORMATION (ADULT FEMALE)

Please provide as complete information as possible, even if you do not feel certain questions pertain to your present condition. All the information you provide is confidential and is useful in determining the best treatment plan for you.

name:_____ date of birth:_____

age:_____ gender (please circle): m or f occupation:_____

street address: _____ home phone:_____

city, state, zip:_____ cell phone:_____

email: _____ work phone:_____

□ single □ married □ divorced □ separated □ widowed □ partnership □ living with □ same sex relationship

emergency contact name: _____ relationship to you:_____

address:_____ home phone:_____

cell phone:_____ work phone:_____

have you had acupuncture before?:_____

how did you hear of us? may we thank someone for referring you?:_____

HEALTH HISTORY

what are your most important health concerns? please list in order of importance:

1. _____ date of onset:_____
2. _____ date of onset:_____
3. _____ date of onset:_____
4. _____ date of onset:_____
5. _____ date of onset:_____

are you under a physician's care for any of your health concerns? (please describe if appropriate):_____

_____

have you sought any other treatment(s) for any of your health concerns? (please describe):_____

_____

is there anything that improves or aggravates your condition?:_____

have you had any blood tests, x-rays, CT scans, MRIs, EKGs, or other tests related to your health concerns within the past year? please list & describe the results to the best of your knowledge and/or memory:

_____

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date of last physical exam:_____ name of physician:_____ physician's phone:_____

please list any hospitalizations and/or surgeries (not including those related to childbirth):

hospitalization / surgery	date	reason

please list any injuries and/or accidents:

accident/injury	date	relation to any health concerns

please indicate if you are taking any of the following:

□ blood thinners (warfarin, coumadin, etc.) □ cortisone or other steroids □ sleeping aids
□ diet pills (diuretics, appetite suppressants, etc.) □ thyroid medication □ laxatives
□ pain relievers (Tylenol, aspirin, etc.) □ tranquilizers/sedatives □ antacids (tums, etc.)

please list all prescription and over-the-counter medications you are currently taking:

name	dosage	reason for taking	date began taking

please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc.):

name	dosage	reason for taking	date began taking

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approximately how many courses of antibiotics have you taken over the past 10 years? _____

Please review the following symptoms and mark an x in the appropriate column (leave blank if you do not experience the symptom):

	occasional	frequent		occasional	frequent
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty in making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		

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do you have a bowel movement every day?: _____#per day/week?:_____

please describe any allergies and/or food sensitivities:_____

_____

_____

_____

LIFESTYLE HISTORY

height:_____ weight:_____ weight one year ago:_____ maximum weight:_____ when?:_____

do you exercise?:_____ how many times a week?_____

what type of exercise?:_____

do you drink coffee/black tea?:_____ # 8 oz cups per day/week?:_____

do you drink soda?:_____ is it caffeinated? _____ # 12 oz glasses per day/week?:_____

how much water do you drink per day?:_____

please describe your typical diet:

breakfast:_____

lunch:_____

dinner:_____

snacks:_____

meals per day:_____ do you eat at regular times each day?:_____

#snacks per day:_____ how often do you eat out (or order in)?:_____

are you vegetarian, vegan, kosher? are there other restrictions to your diet?:_____

_____

do you experience any gas, burping, bloating, acid reflux or other digestive symptoms after eating any foods?:

_____

Do you use tobacco?:_____ how many times per day/week?:_____

have you used tobacco in the past?:_____ when did you stop?:_____

do you drink alcoholic beverages?:_____ how many drinks do you have per day/week?:_____

do you use recreational drugs?:_____ how many times per day/week/month/year?:_____

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have you been treated for drug/alcohol addiction?:_____

hours you sleep per night:_____ time you go to bed:_____ wake up?:_____

do you sleep well?:_____ do you awake feeling rested?:_____

what is your average stress level (*1 is lowest, 10 is highest*) please circle: 1 2 3 4 5 6 7 8 9 10

what is your average energy level (*1 is lowest, 10 is highest*) please circle: 1 2 3 4 5 6 7 8 9 10

at what time of day is your energy typically at its best?: _____ at its worst?:_____

how do you feel about the following areas of your life?

	great	**good**	**fair**	**poor**	**bad**
significant other					
family relations					
friendships					
living arrangements					
self image					
sex					
work					
vacations/time off					
exercise					
spirituality					

how much change are you willing to/able to make at this time to improve your health (please circle)

minimal some complete

FAMILY HISTORY

father's current age:_____ please circle: good health poor health deceased (cause & age:_____)

mother's current age: _____ please circle: good health poor health deceased (cause& age:_____)

please indicate whether you or any family member has, or has had in the past, any of the following conditions:

disorder/illness	**which family member (include yourself) give important details**	**date**	**frequency (if applicable)**
alcoholism/addictions			
allergies/asthma			
alzheimer's disease			
anemia			
arthritis			
autoimmune disorders			
birth defects			
bleeding disorders			
blood clots			
cancer (specify type)			

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disorder/illness	which family member (include yourself) give important details	date	frequency (if applicable)
depression/anxiety			
diabetes			
epilepsy			
gallbladder problems			
glaucoma			
heart disease			
heart murmurs			
hepatitis			
high cholesterol			
high blood pressure			
HIV/AIDS			
infectious disease			
kidney disease			
kidney stones			
mental illness			
osteoporosis			
pacemaker or defibrillator			
shingles			
stroke			
tuberculosis			
urinary tract infections			
yeast infections			

FOR WOMEN

are you still menstruating?:_____ age menses began:_____ date of last period:_____

are you now pregnant?:_____ date of your last ob/gyn exam:_____

# of live births:_____ total # of pregnancies:_____ # of miscarriages:_____ # of terminations:_____

pregnancy	year	length of pregnancy	hours of labor	type of delivery	sex	weight	complications
first							
second							
third							
fourth							

are you sexually active?:_____ STD's?:_____

what form of birth control do you currently use?:_____ how long have you used it?:_____

what other types of birth control have you used in the past?:_____

do you experience any sexual difficulties? (please describe):_____

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is your fertility an issue? (please describe):_____

what (if any) treatment have you sought for your fertility? has it been successful?:_____

_____

	occasional	frequent		occasional	frequent
endometriosis			fibrocystic breasts		
ovarian cysts			breast cancer		
uterine fibroids			breast lumps		
abnormal pap smear			nipple discharge		
yeast infections			vaginal discharge or odor		
urinary tract infections			herpes		
pain/itching of genitalia			human papilloma virus (HPV)		
genital lesions/discharge			hysterectomy		
pelvic inflammatory disease (PID)			uterine prolapse		

# of days between periods:_____ # of days you bleed:_____ do you bleed between periods?:_____

color of menstrual blood:
____ pale/light red ____ dark red
____ red ____ dark red/brown
____ bright red ____ clots

amount of blood:
____ spotting ____ heavy
____ light
____ even throughout

# of pads/tampons used:
____ day 1 ____ day 4
____ day 2 ____ day 5
____ day 3 ____ day 6+

are your periods painful? before period:_____ during period:_____ after period:_____

is the pain:
____ mild
____ moderate

is the pain located in:
____ low abdomen ____ thighs
____ low back ____ other

is the quality of the pain:
____ cramping ____ aching ____ burning
____ stabbing ____ dull ____ constant
____ comes & goes

other symptoms related to your period:

	occasional	frequent		occasional	frequent
discharge			swollen or painful breasts		
headaches			mood swings		
nausea			increased appetite		
constipation			decreased appetite		
diarrhea			insomnia		

is there anything else you would like us to know?:_____

_____

_____

thank you for taking the time to answer these questions. we appreciate your time and effort.
i certify that the information I have provided above is correct and accurate to the best of my knowledge.

_____ _____ _____
Patient's (or Patient Representative's) Signature *Patient's Name* *Date*

_____ _____
Patient Representative's Name *Representative's relationship to patient*

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