

SourcePoint Health
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Everything listed will be held in the strictest of confidence

Full Name: _____ Date: _____

Date of Birth: _____ Address: _____

Phone: _____ Email: _____

Gender: _____ Circle one: Single/Married/Separated/Divorced/Widowed

Place and Type of Work: _____

MEDICAL HISTORY

What is the reason that you have come in for treatment?

List your primary symptoms and how long these have been present. (days/weeks/months/years)

What are your goals for treatment?

What diagnoses have been made by your physicians?

Do you have any electrical devices in your body? i.e. pacemaker, etc. Yes No

Please list any words, topics, or emotional triggers that I should be aware of as your practitioner.

Women: Are you pregnant or do you think might you be pregnant? (Circle one) Yes No

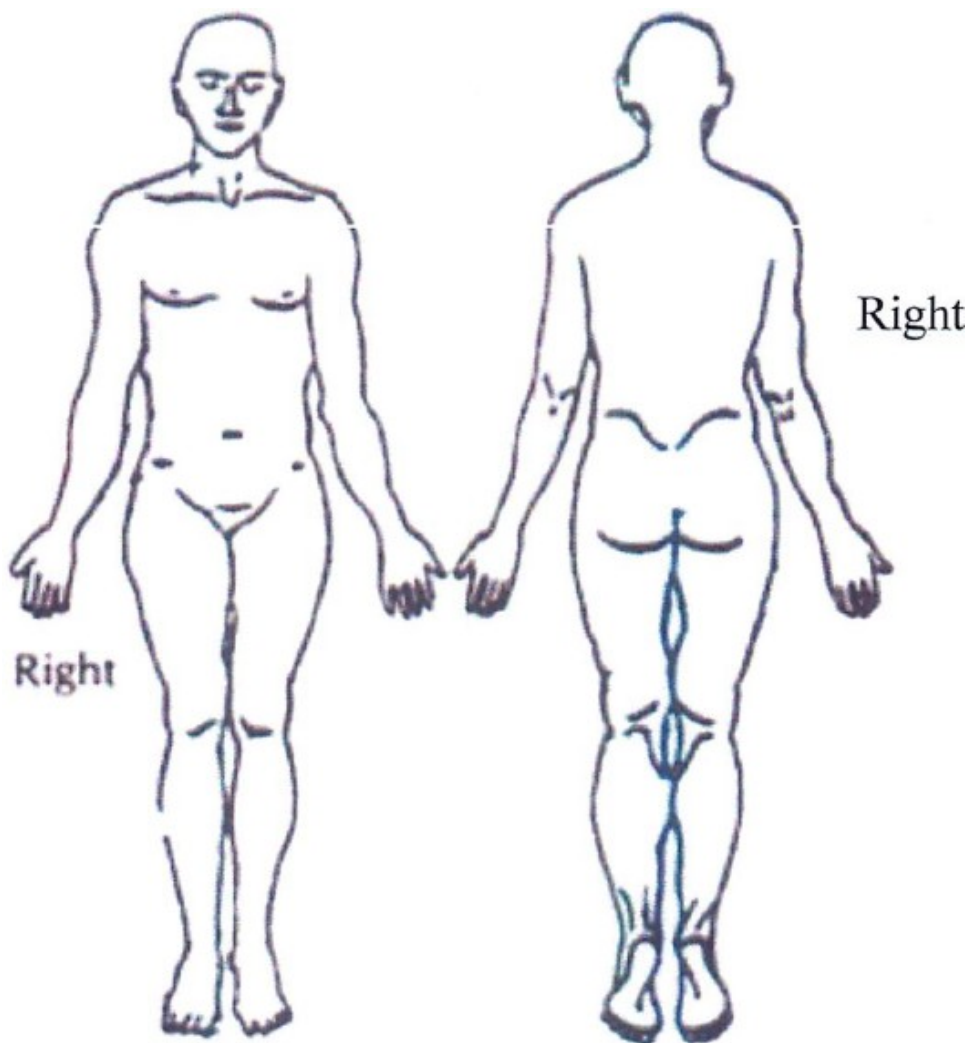
Any previous hospitalizations or surgeries? If yes, include dates and reason for surgery:

Emergency contact: (Name & phone #) _____

Do you have pain? Yes/No _____ Where? _____

Please rate your pain on a scale from 1 to 10, in which 10 is the worst pain imaginable:

Please circle any areas of pain on the images below. Mark any scars, piercings on the diagram even if you got them years ago. If you've had spinal anesthesia or spinal taps, please mark them.



Does your pain interfere with your sleep? Y/N _____ If yes, how? _____

Does your pain interfere with your work? Y/N _____ If yes, how? _____

Frequency of pain: Occasional _____ Frequent _____ Constant/Nearly constant _____

Please circle all that apply: Aching Burning Sharp Numb Stabbing Tingling Dull

Stiffness Shooting Muscle Spasm Muscle Ache Radiating Pain Cramping Swelling

Redness Dizziness Fatigue Difficulty Sitting/Standing Headache

X-rays taken or other scans taken? Y/N _____ If so, of what and when? _____

Major/Chronic Illnesses and the Medications taken for illness

Check if any of the following apply to you

☐ Diabetes	☐ Liver Disease, Hepatitis	☐ Respiratory Disease
☐ High Blood Pressure	☐ Cancer	☐ HIV (optional)
☐ Neurological Disease	☐ Kidney Disease	☐ Infectious Disease
☐ Heart Disease	☐ Thyroid Disease	☐ Gastrointestinal Disease

Do you take thyroid medication?

☐ No ☐ Yes, if yes list it here:

Primary care physician: _____ Contact info: _____

Other healthcare providers: _____ Contact info: _____

Other healthcare providers: _____ Contact info: _____

Who referred you to this office? _____

For Female Patients

Date of last menstrual cycle: _____ Pregnancies: _____ # of children: _____

Cramping: None Minor Strong Severe Breast tenderness: Y/N

Describe your mood or symptoms the week leading up to your period: _____

Menopause? (Circle which apply) Pre Peri Post

For All Patients

Sleep

☐ I can't go to sleep until after 11pm☐ Go to sleep but awaken at:☐ 11pm to 1am ☐ 3am to 5am☐ 1am to 3am ☐ 5am to 7am

Fatigue

☐ I have a problem with fatigue. It is worst during:☐ 5am to 7am ☐ 1pm to 3pm☐ 7am to 9am ☐ 3pm to 5pm☐ 9am to 11am ☐ 5pm to 7pm☐ 11am to 1pm ☐ 7pm to 9pm

Other Medical Conditions that you would like support with, even if you never thought Acupuncture could treat it: _____

Drugs, supplements or herbs taken in addition to what you listed above: _____

Known drug allergies:

Check if you use regularly use any of following:

- | | |
|---|--------------------------------------|
| ☐ Tobacco | ☐ Splenda |
| ☐ Alcohol | ☐ Saccharine |
| ☐ Coffee | ☐ Diet drinks |
| ☐ Caffeinated tea | ☐ MSG |
| ☐ Prescription or non-prescription drugs | ☐ Soy |
| ☐ Nutrasweet | |

Family History:

List any illnesses that tend to run in your family: _____

Review of Body Systems and Symptoms

List any pertinent history of problems, diagnoses, surgery, etc. involving each of the following along with the dates. If none, write N/A.

Head, Eyes, Ears, Nose, Throat:

Cardiovascular:

Respiratory:

Gastrointestinal:

Genitals & Urinary:

Musculoskeletal:

Neurological:

Skin:

Immune System:

Anything else you want me to know:

Are there any previous experiences or traumas that you believe contributed to the current symptoms you're seeking relief from?

Dental Information

Please answer the following or ask your dentist if you don't know:

Tooth numbers for all Root Canals: _____ (If no Root Canals write "0")

Tooth numbers for all Crowns: _____ (If no Crowns write "0")

Tooth numbers for all Extracted teeth: _____ (If no Extractions write "0")

Anything else you want me to know:

Are there any previous experiences or traumas that you believe contributed to the current symptoms you're seeking relief from?
