Lisa Wood, L.Ac
21 Simmons Street, Millerton, NY 12546 1 Union Square West, Ste. 715, New York, NY 10003

PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

First Name: M.I. Last Name: DOB: / / /

Address: City: State: Zip:

Home Phone ( ) Cell ( ) Work ( )

Emergency Contact: Telephone ( )

Male Female / Married Single Divorced / Name of Spouse:

Occupation: Employer:

Referred By (name): Friend Relative Insurance Other

I. What would you most like to achieve through your work with acupuncture ?

1.

2.

3.

4.

5.

II. List in order of importance your symptoms and their duration.

1.

2.

3.

4.

5.

III. How long have you had these symptoms ?

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Name_____DOB:_____/_____/_____

IV. How and where did they first occur ?

V. What do you think is the cause ?

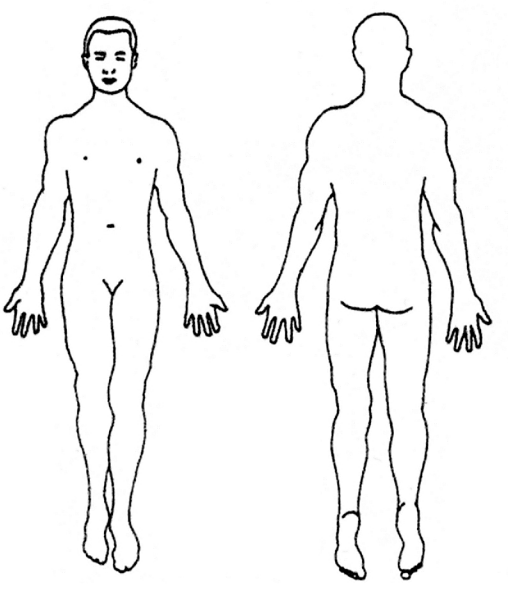
VI. What makes these symptoms feel better or worse ?

ARE YOU EXPERIENCING PAIN/DISCOMFORT IN ANY AREA OF YOUR BODY ?

YES / NO

If YES,
USE THE DIAGRAMS BELOW TO INDICATE THE PAINFUL OR DISTRESSED AREAS

indicate the location of the symptoms by using the letters that best describe them
X = sharp/stabbing // P = pins & needles // D = dull ache // N = numbness



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Name_____DOB:_____/_____/_____

Medical History:

Please check all that apply	*Date Diagnosed*		*Date Diagnosed*
Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	High Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

Surgical History:

_____ Date _____

_____ Date _____

_____ Date _____

Family History:

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

Medications / Supplements:

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

Allergies (to medications, chemicals or foods):

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Name_____DOB:_____/_____/_____

Nutrition:

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet?
(ie Vegetarian, Vegan, Low Carb, etc.)

_____

2. What do you eat on a "typical" day? _____
a) Breakfast _____
b) Lunch _____
c) Dinner _____
d) Snacks _____
e) Foods you tend to crave: _____
f) Foods you dislike: _____

Social History:

1. How much per day do you use of the following?
a) Coffee, tea, soft drinks: _____
b) Alcohol: _____
c) Cigarettes, cigars, other tobacco: _____
d) Other drugs: _____

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?

_____

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms?

_____

_____

7. In the past year, how many days have been significantly affected by your health? _____

8. How many days did you feel generally poor? _____

9. How many times were you in the hospital? _____

10. Please describe your current exercise regimen:
Hours per week: _____ Activities: _____ [ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? _____

12. Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

13. Who would you describe as your source of primary social support? (relationship to you)

Other Information:

Please list and briefly describe the most significant events in your life:
1. _____
2. _____
3. _____
4. _____

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No