

Four Winds Acupuncture
Jean S Caron, D.O.M., A.P., L.M.T.
Crystal C. Maples, D.O.M, A.P., CHT.

PATIENT INFORMATION FORM

General Patient Information

Name _____ SS# _____ Date _____

Birthdate / / Age _____

Marital Status Married Single Other Gender M F

Address _____

City _____ State _____ Zip _____

Home Phone (____) ____-____ Cell (____) ____-____

Best # to Call with information regarding appointments: (Please Circle One) Home Cel Work

E-Mail _____@_____

Is it OK to e-mail you with events and newsletters? Please circle one: yes no

Is it Ok to e-mail you with appointment reminders? Please circle one: yes no

Employer _____

Occupation _____

Work Phone (____) ____-____

Emergency Contact Name _____ Relationship to Patient _____

Phone (____) ____-____

How were you referred? Please specify

Flyer / Magazine _____ Phone Book _____

Doctor/Physician _____ Friend/ Relative _____

Internet _____ Seminar _____

Other _____

We consider it our greatest priority to provide a comfortable and healing environment for our patients. All answers are strictly confidential and will only be used to create the best form of care. Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but may play a significant role in your diagnosis and treatment.

Name _____ Date _____

Age _____ Weight _____ Height _____

Patient Medical History

Major Complaint(s), in order of significance to you:

1. Major Complaint: _____

2. Secondary Complaint: _____

3. Other Complaint: _____

Medications (if any): _____

Supplements (if any vitamins, herbs, etc.): _____

Surgeries / Injuries (please include dates) _____

Recent tests: (please indicate test results and date below)

Physical Cholesterol Blood Prostate HIV STD Pap Smear

Mammography Other _____

Test Results and Date: _____

Check any you have had in the past:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Migraines | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> other liver illness | <input type="checkbox"/> other kidney illness | <input type="checkbox"/> other spleen illness | <input type="checkbox"/> other lung illness |
| <input type="checkbox"/> other heart illness | <input type="checkbox"/> other stomach illness | | |

Other: _____

Family Medical History

Check the following that have occurred in your blood relatives:

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other_____ | | |

Patient Profile

Please clearly mark any areas of pain on the diagram on the following page:

Is the pain:

- Sharp Burning Aching Cramping Dull Moving Fixed Other:_____

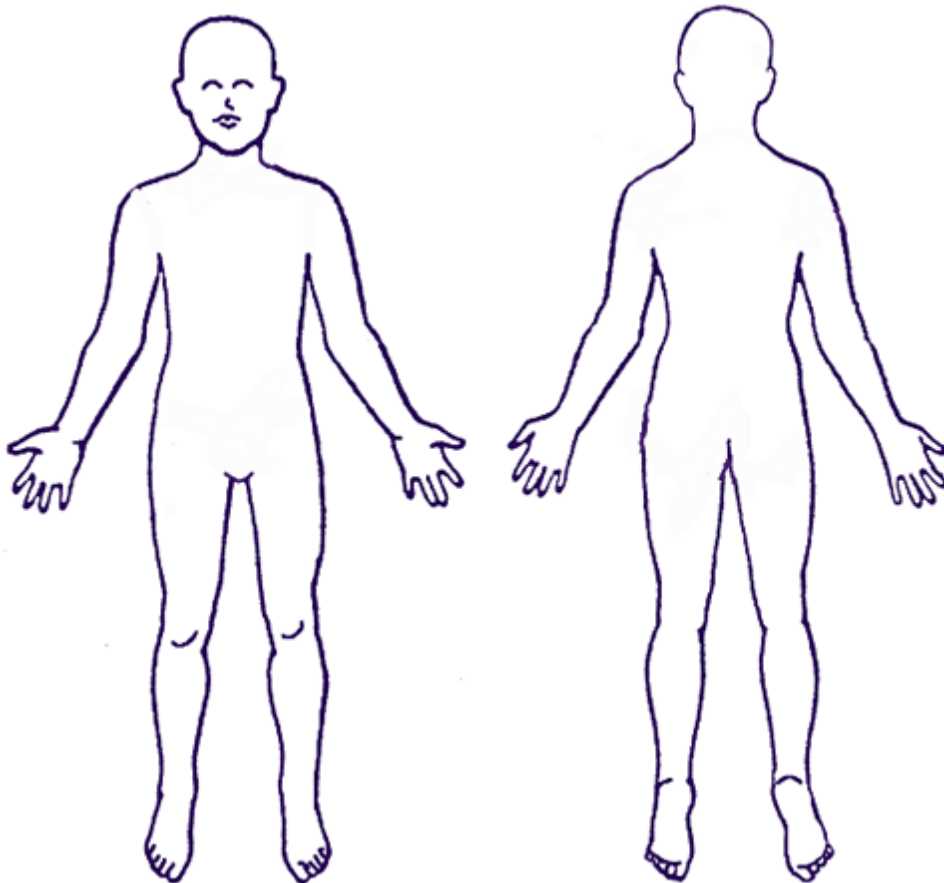
Do the following lessen the pain?

- Pressure Cold Heat Exercise Other:_____

Do the following worsen the pain?

- Pressure Cold Heat Exercise Other:_____

Please indicate below on diagram with an X where your pain or discomfort is:



Please check any of the following that pertain to you:

Overall Temperature (Kidney function):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> cold hands | <input type="checkbox"/> cold feet | <input type="checkbox"/> sweaty hands | <input type="checkbox"/> sweaty feet |
| <input type="checkbox"/> afternoon flushes | <input type="checkbox"/> hot flushes | <input type="checkbox"/> night sweats | <input type="checkbox"/> hot sensation |
| <input type="checkbox"/> cold sensation | <input type="checkbox"/> perspire easily | <input type="checkbox"/> lack of perspiration | <input type="checkbox"/> thirsty |
| <input type="checkbox"/> low energy | <input type="checkbox"/> vaginal dryness | | |

Eyes (Liver function):

- | | | | |
|---------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> itchy | <input type="checkbox"/> bloodshot | <input type="checkbox"/> hot | <input type="checkbox"/> dry |
| <input type="checkbox"/> watery | <input type="checkbox"/> gritty / sandy | <input type="checkbox"/> blurry vision | <input type="checkbox"/> see floaters |

Overall Energy (Kidney, Spleen, Lung function):

- | | | | |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> low energy | <input type="checkbox"/> easily catch colds | <input type="checkbox"/> general weakness | <input type="checkbox"/> shortness of breath |
|-------------------------------------|---|---|--|

Blood (Liver Spleen, Heart function):

- | | | | | |
|------------------------------------|--------------------------------------|------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> poor memory | <input type="checkbox"/> pale skin | <input type="checkbox"/> fatigue | <input type="checkbox"/> graying hair |
|------------------------------------|--------------------------------------|------------------------------------|----------------------------------|---------------------------------------|

Heart function:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> palpitations | <input type="checkbox"/> anxiety | <input type="checkbox"/> restlessness | <input type="checkbox"/> sores on tongue |
| <input type="checkbox"/> mental confusion | <input type="checkbox"/> vivid dreams | <input type="checkbox"/> chest pain | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> mental fogginess | <input type="checkbox"/> mental sluggishness | <input type="checkbox"/> wake unrefreshed | |

Lung function:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> cough | <input type="checkbox"/> sinus congestion | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> dry mouth |
| <input type="checkbox"/> dry throat | <input type="checkbox"/> dry nose | <input type="checkbox"/> dry skin | <input type="checkbox"/> sneezing |
| <input type="checkbox"/> body aches | <input type="checkbox"/> stiff neck | <input type="checkbox"/> stiff shoulders | <input type="checkbox"/> sore throat |
| <input type="checkbox"/> difficult breathing | <input type="checkbox"/> melancholy | <input type="checkbox"/> chills & fever | <input type="checkbox"/> nasal discharge /color: _____ |
| <input type="checkbox"/> allergies/to what: _____ | | | |
| <input type="checkbox"/> headache/location: _____ | | | |
| <input type="checkbox"/> smoke cigarettes/#per day: _____ | | | |

Spleen function:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> low appetite | <input type="checkbox"/> bloating | <input type="checkbox"/> abrupt weight change | <input type="checkbox"/> gas |
| <input type="checkbox"/> gurgling stomach | <input type="checkbox"/> easily bruise | <input type="checkbox"/> fatigue after eating | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> over-thinking | <input type="checkbox"/> worry | <input type="checkbox"/> organ prolapsed | <input type="checkbox"/> constipation |
| <input type="checkbox"/> loose stools | <input type="checkbox"/> diarrhea | <input type="checkbox"/> blood in stools | <input type="checkbox"/> mucous in stools |
| <input type="checkbox"/> incomplete stools | <input type="checkbox"/> undigested food in stools | | |

Dampness:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> swollen hands | <input type="checkbox"/> swollen feet | <input type="checkbox"/> swollen joints | <input type="checkbox"/> chest congestion |
| <input type="checkbox"/> nausea | <input type="checkbox"/> snoring | <input type="checkbox"/> heavy body sensation | |

Stomach function:

- | | | | |
|------------------------------------|--------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> burning | <input type="checkbox"/> bad breath | <input type="checkbox"/> very large appetite | <input type="checkbox"/> canker sores |
| <input type="checkbox"/> heartburn | <input type="checkbox"/> acid reflux | <input type="checkbox"/> bleeding or swollen gums | <input type="checkbox"/> ulcer |
| <input type="checkbox"/> belching | <input type="checkbox"/> hiccups | <input type="checkbox"/> stomach pain | <input type="checkbox"/> vomiting |

Liver/Gallbladder function:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> anger easily | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> bitter taste |
| <input type="checkbox"/> frustration | <input type="checkbox"/> depression | <input type="checkbox"/> frequent headaches | <input type="checkbox"/> irritability |
| <input type="checkbox"/> tingling | <input type="checkbox"/> numbness | <input type="checkbox"/> muscles spasms | <input type="checkbox"/> seizures |
| <input type="checkbox"/> twitching | <input type="checkbox"/> convulsions | <input type="checkbox"/> lump in throat | <input type="checkbox"/> muscle tension |
| <input type="checkbox"/> drink alcohol | <input type="checkbox"/> gall-stones | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> sexual disease |
| <input type="checkbox"/> alternating diarrhea and constipation | | | |

Kidney/Bladder function:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> sore/weak knees | <input type="checkbox"/> low back pain | <input type="checkbox"/> easily broken bones | <input type="checkbox"/> memory problems |
| <input type="checkbox"/> excessive hair loss | <input type="checkbox"/> kidney stones | <input type="checkbox"/> lack of bladder control | <input type="checkbox"/> fearful |
| <input type="checkbox"/> high libido | <input type="checkbox"/> low libido | <input type="checkbox"/> normal libido | |

Urination:

- | | | | |
|--------------------------------------|----------------------------------|--|--|
| <input type="checkbox"/> frequent | <input type="checkbox"/> urgent | <input type="checkbox"/> dark yellow color | <input type="checkbox"/> reddish color |
| <input type="checkbox"/> clear color | <input type="checkbox"/> scanty | <input type="checkbox"/> profuse | <input type="checkbox"/> strong odor |
| <input type="checkbox"/> burning | <input type="checkbox"/> painful | <input type="checkbox"/> difficult | <input type="checkbox"/> cloudy |

Men only:

- | | | | |
|--|---|--|------------------------------------|
| <input type="checkbox"/> testicular pain | <input type="checkbox"/> swollen testes | <input type="checkbox"/> premature ejaculation | <input type="checkbox"/> impotence |
| <input type="checkbox"/> coldness or numbness in genitalia | <input type="checkbox"/> other: _____ | | |

Women only:

Age of first menses: _____ Number of children: _____ Age of menopause: _____

Are you pregnant now? _____

Vaginal discharge: color: _____ thin/thick: _____ strong odor: _____

Bleeding between periods: color: _____ clots: _____ cramps: _____

Frequency of bleeding: _____

Do you experience any of the following pre-menstrual syndromes?

- | | | | |
|------------------------------------|--|--|------------------------------------|
| <input type="checkbox"/> nausea | <input type="checkbox"/> food cravings | <input type="checkbox"/> depression | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> headaches | <input type="checkbox"/> irritability | <input type="checkbox"/> water retention | <input type="checkbox"/> migraines |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> cramps | <input type="checkbox"/> breast tenderness | <input type="checkbox"/> emotional |

Days in menstrual cycle: _____

Average number days of flow: _____