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Singing Crane Acupuncture, LLC
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New Patient Information Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name:_____ Gender: _____Today's Date:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone:_____ Cell: _____

Email:_____ Leave Message: __home __ cell __ email

Marital/Partnered Status: _____ Your Date of Birth:_____

Emergency Contact: _____ Telephone: _____ Relationship: _____

How did you hear about Singing Crane Acupuncture? _____

1. Are you currently receiving health care? Yes /No If yes, where and from whom?

_____

If no, when and where did you last receive health care? _____

For what _____

2. Has your case been referred to an attorney (Work Comp, personal injury or motor vehicle injury claim, etc.)? Yes/ No

3. Please identify your health concerns in order of importance:

Condition	Past Treatment
a. _____	_____
b. _____	_____
c. _____	_____

*Patient Name:*_____ *Date of Birth :*_____

How do these conditions affect you?

_____

What are your goals for the treatment? _____

_____

4. Are you pregnant or is there any possibility you could be pregnant? Yes/ No

5. Do you have any chronic infectious diseases? Yes/No If yes, please explain:

_____

6. Are you currently suffering from any chronic illness? Yes/ No If yes, please explain:

_____

_____

7. Significant diseases, injuries, accidents, hospitalizations, surgeries, scars, X-Rays/CAT Scans/MRI/NMR/Special Studies

Reason	When	Reason	When

8. Please list any prescriptive medications, over-the-counter medications, vitamins, and supplements that you are currently taking and give your dosage: (Or provide a list of medications)

9. Please list any foods, drugs, or medications you are hypersensitive or allergic to and please include how it affects you.

_____

_____

_____

_____

10. Height: _____ Weight _____ Past MaxWeight: _____ When? _____

*Patient Name:*_____ *Date of Birth :*_____

11. What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____ What is your cholesterol?_____

12. Immunizations (please circle any that you have had):
Polio Tetanus Measles/Mumps/Rubella Pertussis/Diphtheria Hepatitis B

Others:_____

13. Family History				
	Mother	Father	Brothers	Sisters
Age if living				
Health (G=good, P=poor)				
Age at death if deceased				
Cause of death				
Check off family illnesses				
Cancer				
Diabetes				
Heart Disease				
Osteoporosis				
High Blood Pressure				
Stroke				
Mental Illness				
Other				

14. Emotional - please put a C for currently experience and P for experienced in the past.

___Mood Swings ___Anxiety ___Easily Angered or Agitated
___Depression ___Mental Tension

Past Traumas_____

_____

_____

15. Energy and Immunity - please put a C for currently experience and P for experienced in the past.

___Fatigue ___Chronic Infections
___Slow Wound Healing ___Chronic Fatigue Syndrome

16. Head, Eye, Ear, Nose & Throat – please put a C for currently experience and P for experienced in the past.

___Ear Ringing ___Sinus Problems
___Hearing loss ___Hay Fever/Allergies

___Nose Bleeds ___Blurry or Failing Vision/ Floaters

*Patient Name:*_____ *Date of Birth :*_____

___TMJ/ Jaw Problems ___Headaches
___Frequent Sore Throat

17. Respiratory - please put a C for currently experience and P for experienced in the past.

___Pneumonia ___Asthma
___Frequent Common Colds ___Difficulty Breathing/ Persistent Cough

18. Cardiovascular - please put a C for currently experience and P for experienced in the past.

___Heart Disease ___Chest Pain ___Poor Circulation
___Rapid/Irregular heart beat ___ High Blood Pressure ___Ankle Swelling

19. Gastrointestinal - please put a C for currently experience and P for experienced in the past.

___Nausea/Vomiting ___Pain over stomach ___Gall Bladder Disease
___Chronic Diarrhea ___Liver Disease ___Hemorrhoids
___Chronic Constipation ___Blood in Stool ___Heartburn/Indigestion
___Excessive Hunger ___Poor Appetite ___Colon trouble
___Excessive Belching ___Excessive Gas/Bloating ___Difficulty Swallowing
___Feeling of Food Retention

20. Genito-Urinary Tract - please put a C for currently experience and P for experienced in the past.

___Kidney Infection ___Kidney Stones ___Painful Urination
___Blood/Pus in Urine ___Nighttime urination ___Inability to control urine
___Decreased Sex Drive

21. Female Reproductive - please put a C for currently experience and P for experienced in the past.
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___Irregular Cycles ___Bleeding Between Periods ___Vaginal Discharge
___Previous Miscarriage ___Menopausal Symptoms ___Excessive menstrual flow
___Extreme Menstrual Pain ___Very Light Menstrual Flow ___PMS
___Pelvic Pain ___Difficulty conceiving ___Clotting
___Breast Lumps/Tenderness ___Nipple Discharge ___Chronic Yeast Infections

22. Menstrual/Birthing History

____Number of Pregnancies ____Number of Live Births
____Number of Days of Menses Days in Cycle ____Number of Miscarriages
____Age of First Period ____Age of last Period
____ Year of Last Pap Smear ____ Number of Abortions
____Type of Birth Control if any

*Patient Name:*_____ *Date of Birth :*_____

23. Male Reproductive - please put a C for currently experience and P for experienced in the past.

___Sexual Difficulties ___Penis Discharge
___Prostate Problems ___Testicular Pain/Swelling

24. Musculoskeletal - please put a C for currently experience and P for experienced in the past.

___Neck/Shoulder Pain/Numbness/Weakness ___Muscle Spasms/Cramps
___Arm Pain/Numbness/Weakness ___Hand Pain/Numbness/Weakness
___Leg Pain/Numbness/Weakness ___Hip Pain/Numbness/Weakness
___Knee Pain/Numbness/Weakness ___Foot Pain/Numbness/Weakness
___Joint Pain ___Tremors
___Back Pain/Sciatica

25. Neurological Problems – please put a C for currently experience and P for experienced in the past.

___Paralysis ___Numbness ___Loss of Balance
___Vertigo/Dizziness ___Seizures ___Stroke

26. Endocrine and metabolic disorders: put a C for currently experience and P for experienced in the past.

___Hypothyroidism ___Hypoglycemia ___Hyperthyroidism
___Diabetes Mellitus ___Night Sweats ___Hair Loss

27. Other - please circle any that you experience currently.

___Anemia ___Cancer ___Itching/Rashes ___Eczema/Hives
___Cold Hands/Feet ___Bruise Easily ___Sore that won't heal ___Restless Legs
___Sudden Weight Loss ___Fainting ___Difficulty to Stop Bleeding ___Brittle Nails
Other_____

28. Lifestyle

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Daily Exercise: _____

_____

Sleep: Excellent, Good or Poor Number of Hours per Night _____
Regular Dreams: Yes/No Regular Nightmares_____

Do you wake feeling rested most mornings? Yes/No

*Patient Name:*_____ *Date of Birth :*_____

c. Occupation: _____ Hours per Week: _____

Employer: _____ Do you enjoy your work? Yes/No

d. Nicotine and Tobacco Use Per Day: _____
e. Caffeine Consumption Per Day: _____
f. Alcohol Consumption Per Week:_____
g. Marijuana Consumption Per Week:_____

h. What do you love to do?_____

_____

29. One Final Question

Is there anything that I haven't asked you that you think I should know in order to provide you with the best level of care?

_____

_____

_____