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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.

___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
Regular Dreams: Yes/No

Number of Hours per Night _____
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?
