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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: ________ Date:________

Street Address: ____

City: ________________________________ State: _________________ Zip Code: ______________

Home Telephone:_______________________________ Cell: __________________________________

Email:____ Leave Message: __home __ cell __ email

Marital/Partnered Status: __________________________ 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	Siblings	
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

___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

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?

____

____

____