

## Jennifer Lyons, L.Ac. : Confidential Case History

This is a confidential health profile to help us determine a treatment plan for you.

### New Patient Information

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Alternate phone \_\_\_\_\_

Sex: M | F | Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Marital Status: Single | Married | Domestic Partner | Divorced | Widowed |

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Referred by? \_\_\_\_\_

Primary Care Physician? \_\_\_\_\_ Phone \_\_\_\_\_

Have you received acupuncture before? \_\_\_\_\_ When/where? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Family Medical History

Please indicate any significant illness that you or a blood relative have had.

(Use an **X** for you, **P** for parent, **S** for sibling, and **R** for other relative)

Cancer _____	Hepatitis _____	High Blood Pressure _____	Hemophilia _____
HIV/AIDS _____	Diabetes _____	Heart Disease _____	Stroke _____
Seizures _____	Emotional Disorder _____	Tuberculosis _____	STDs _____
Substance Abuse _____	Thyroid Disease _____	Allergies _____	Eating Disorder _____

**Personal Health Information**

What is the main problem for which you are seeking treatment?

What is the severity of your condition (1 to 10, 1 is best, 10 is worst/unbearable):

How long have you had this health concern?

Is there any time of day in which your condition is worse?

What makes your condition better? (Rest, heat, ice, ect.)

What makes your health condition worse?

What other forms of treatment have you sought for this condition?

List in their order of priority any other health problems you have now:

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

List any allergies, food sensitivities and food cravings that you have:

List any accidents, surgeries or hospitalizations (include date):

Do you have any prosthetic devices, pacemakers, metal pins, ect. in your body? \_\_\_\_\_

Are you taking any blood thinners? (Coumadin, Warfarin, Heparin) \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ If Yes, how many months? \_\_\_\_\_

**Pregnancy and Gynecology**

Date of last menstrual period \_\_\_\_\_ # of days period typically lasts \_\_\_\_\_

Do you take oral contraceptives? \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_

# of miscarriages \_\_\_\_\_ Age of menopause \_\_\_\_\_ Hormone replacement therapy? \_\_\_\_\_

Please put a √ if you experience the following conditions:

Heavy flow \_\_\_\_\_ Scanty flow \_\_\_\_\_ Spotting (mid-cycle) \_\_\_\_\_ Painful menses \_\_\_\_\_ clots \_\_\_\_\_

Vaginal discharge \_\_\_\_\_ Uterine prolapse \_\_\_\_\_ PMS \_\_\_\_\_ Uterine Fibroids \_\_\_\_\_ PCOS \_\_\_\_\_

**Personal Lifestyle Habits**

Cigarettes (packs) \_\_\_\_\_ Coffee/Tea (cups) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_

Marijuana \_\_\_\_\_ Other recreational drugs \_\_\_\_\_

Vitamins & herbs \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Food cravings \_\_\_\_\_

Diet: What might you eat on a typical day?

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Exercise \_\_\_\_\_ How often? \_\_\_\_\_

What non-work activities do you enjoy doing? \_\_\_\_\_

**Medications**

Prescription drugs you are currently taking:

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over-the-counter medication you are currently taking:

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems:** Please put a "C" if the condition is current or a "P" if you had it in the past

**General**

- \_\_\_ Insomnia
- \_\_\_ Dreams/ nightmares
- \_\_\_ Irritability
- \_\_\_ Depression
- \_\_\_ Mood swings
- \_\_\_ Anxiety
- \_\_\_ Fatigue
- \_\_\_ Poor memory
- \_\_\_ Recent weight loss/gain
- \_\_\_ Chills
- \_\_\_ Fever

**Head & Neck**

- \_\_\_ Headaches
- \_\_\_ Migraines
- \_\_\_ Stiff neck
- \_\_\_ Dizziness
- \_\_\_ Fainting
- \_\_\_ Swollen glands

**Ears**

- \_\_\_ Ringing
- \_\_\_ Hearing loss
- \_\_\_ Infections
- \_\_\_ Earache
- \_\_\_ Hearing aids
- \_\_\_ Vertigo

**Eyes**

- \_\_\_ Glasses/ contact lenses
- \_\_\_ Blurred vision
- \_\_\_ Poor night vision
- \_\_\_ Spots or floaters
- \_\_\_ Eye inflammation
- \_\_\_ Double vision
- \_\_\_ Glaucoma
- \_\_\_ Cataracts

**Nose, Throat & Mouth**

- \_\_\_ Sinus infection
- \_\_\_ Hay fever/ allergies
- \_\_\_ Frequent sore throat
- \_\_\_ Difficulty swallowing
- \_\_\_ Mouth & tongue ulcers
- \_\_\_ Frequent colds
- \_\_\_ Nosebleed
- \_\_\_ Nasal congestion
- \_\_\_ Loss of voice
- \_\_\_ Thirst
- \_\_\_ TMJ
- \_\_\_ Gum problems
- \_\_\_ Dry mouth

**Skin**

- \_\_\_ Hives
- \_\_\_ Rashes
- \_\_\_ Eczema/ psoriasis
- \_\_\_ Night sweating
- \_\_\_ Excess sweating
- \_\_\_ Dry skin
- \_\_\_ Easy bruising
- \_\_\_ Changes in moles, lumps
- \_\_\_ Itching

**Respiratory**

- \_\_\_ Difficulty breathing
- \_\_\_ Wheezing/Asthma
- \_\_\_ Chronic cough
- \_\_\_ Coughing up phlegm
- \_\_\_ Coughing up blood
- \_\_\_ Shortness of breath
- \_\_\_ Tight chest
- \_\_\_ Cold hands and feet

**Cardiovascular**

- \_\_\_ High blood pressure
- \_\_\_ Low blood pressure
- \_\_\_ Chest pain or tightness
- \_\_\_ Palpitation
- \_\_\_ Rapid heart beat
- \_\_\_ Irregular heart beat
- \_\_\_ Poor circulation
- \_\_\_ Swollen ankles
- \_\_\_ History of blood clots
- \_\_\_ Anemia
- \_\_\_ History of heart attack

**Gastrointestinal**

- \_\_\_ Nausea
- \_\_\_ Indigestion
- \_\_\_ Stomach pain
- \_\_\_ Diarrhea
- \_\_\_ Constipation
- \_\_\_ Poor appetite
- \_\_\_ Excessive hunger
- \_\_\_ Vomiting
- \_\_\_ Gas
- \_\_\_ Hiccups
- \_\_\_ Acid regurgitation
- \_\_\_ Bloating
- \_\_\_ Laxative use
- \_\_\_ Bloody stool
- \_\_\_ Mucus in stool
- \_\_\_ Hemorrhoids

- \_\_\_ Gall Bladder disorder

**Musculoskeletal**

- \_\_\_ Joint pain/disorder
- \_\_\_ Sore muscles
- \_\_\_ Weak muscles
- \_\_\_ Difficulty walking
- \_\_\_ Neck/shoulder pain
- \_\_\_ Upper back pain
- \_\_\_ Lower back pain
- \_\_\_ Rib pain
- \_\_\_ Limited range of motion
- \_\_\_ Other (describe)

**Neurological**

- \_\_\_ Seizures
- \_\_\_ Tremors
- \_\_\_ Numbness or tingling
- \_\_\_ Pain
- \_\_\_ Paralysis
- \_\_\_ Poor coordination
- \_\_\_ Other (describe)

**Genito-urinary**

- \_\_\_ Pain on urination
- \_\_\_ Frequent urination
- \_\_\_ Urgent urination
- \_\_\_ Blood in urine
- \_\_\_ Unable to hold urine
- \_\_\_ Incomplete urination
- \_\_\_ Bedwetting
- \_\_\_ Wake to urinate
- \_\_\_ Increased libido
- \_\_\_ Decreased libido
- \_\_\_ Kidney stones
- \_\_\_ Impotence
- \_\_\_ Premature ejaculation
- \_\_\_ Nocturnal emission
- \_\_\_ Pain/itching of genitalia
- \_\_\_ Lumps in testicles

**Infection Screening**

- \_\_\_ HIV risks: self or partner
- \_\_\_ TB: self or household
- \_\_\_ Hepatitis risk
- \_\_\_ Gonorrhea
- \_\_\_ Chlamydia
- \_\_\_ Syphilis
- \_\_\_ Genital warts
- \_\_\_ Herpes: oral/ genital