New Patient Health Care Analysis

Today's Date: _____

Patient Information:

First Name: _____	**Last Name:** _____	**Email:** _____	
Address: _____		**City:** _____	**State:** _____ **Zip Code:** _____
Home Phone: _____	**Work Phone:** _____	**Cell Phone:** _____	**Date of Birth:** _____
Height: _____	**Weight:** _____	**Marital Status:** ☐ S ☐ M ☐ D ☐ W	**Gender:** ☐ M ☐ F
How did you hear about us?: _____		**If referred by someone, who?:** _____	

Please answer the following questions honestly so we can do our best to help you reach your goals

Have you ever had ACUPUNCTURE before?

- ❑Yes
- ❑No

Experience?

- ❑Positive
- ❑Negative

Any Concerns? _____

Reason for Visit (Primary Health Concern):

_____

HOW LONG have you been suffering from this problem? Recent/Chronic

_____

HOW OFTEN do you find yourself suffering….. daily? Ocassional?

_____
_____
_____

HOW SEVERE do you find the pain at its worst?

_____
_____
_____

ANYBODY ELSE IN YOUR FAMILY suffering the same or similar problems?

Who	What problem	Receiving care	Live locally
1. _____			Y N
2. _____			Y N
3. _____			Y N

Explain to me in your own words, HOW DOES IT FEEL, at it's WORST?

_____
_____
_____
_____

Before you began to suffer with this problem, was there a CHEMICAL, PHYSICAL OR EMOTIONAL STRESS/TRAUMA or a CONDITION that is directly or indirectly related to this problem?

- ❑Yes
- ❑No

Start with the most severe:

1. _____
2. _____
3. _____
4. _____
5. _____

Since you began suffering with this problem, HAVE YOU TRIED ANYTHING TO FIX THIS PROBLEM?

- ❑Yes
- ❑No

What WAS the RESULT? _____

Any PRESCRIPTION MEDICATIONS you are CURRENTLY TAKING?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

- ❑ Do you have any CONCERNS about your liver or other organs?

Since you began suffering with this problem, what HAVE YOU TRIED that HAS NOT worked? (such as ice, heat, rest, over the counter drugs, other prescription meds, etc.)

1. _____

2. _____

3. _____

Do you feel DISCOURAGED ABOUT THIS?

- ❑ Yes
- ❑ No

Give me an example of a day WHEN YOUR PROBLEM WAS AT ITS WORST. How did it affect your:

- ❑ Family or spouse_____
- ❑ Work (absenteeism or productivity)_____
- ❑ Hobbies_____

WHAT ACTIVITY DOES THIS PROBLEM PREVENT YOU FROM DOING, either partially our totally, that you would really like to be doing again?

_____
_____
_____

Has this problem INTERUPTED YOUR SLEEP PATTERN?		Yes	No
1.	Trouble falling asleep	✗	✗
2.	Not enough restful sleep	✗	✗
3.	Awakening in the middle of the night	x	✗
4.	Waking earlier than you normally would	✗	✗
5.	Other	✗	✗

HOW LONG has this problem been going on_____ years/months?

What do you think is going to happen if this PROBLEM GOES FOR ANOTHER_____months/years?_____

How do you feel mostly throughout the day? ☐ Tired/Fatigued ☐ Energetic/Alert

How do you feel overall on a daily basis?

Unwell 1 2 3 4 5 Very well

How often do you find yourself sad or depressed for no definitive reason?

Never 1 2 3 4 5 All the time

Please rate your overall health:

Not healthy 1 2 3 4 5 Very healthy

Your level of interest in losing weight is:

Not interested 1 2 3 4 5 Very interested

Are you ready to make significant lifestyle changes?

Not ready 1 2 3 4 5 Very ready

How much support can your friends and/or family provide?

No support 1 2 3 4 5 Lots of support

How committed are you to making this change in your life right now?

Not committed 1 2 3 4 5 Nothing can stop me!