

**Harmony and Health Acupuncture**  
**2001 E Campbell Avenue Suite 102 Phoenix, AZ 85016**

**Confidential Patient Information Form**

**PERSONAL INFORMATION**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Best Way to Reach You \_\_\_\_\_

Email Address \_\_\_\_\_ Please check if you are willing for us to contact you by email  Yes  No

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_ Age(s) of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Highest level of education completed  High School  Bachelors  Masters  Doctorate  Professional  Other \_\_\_\_\_

In emergency notify: \_\_\_\_\_ Emergency Phone Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Last Seen: \_\_\_\_\_

**MEDICAL INFORMATION**

Have you had acupuncture before?  No  Yes Name of Acupuncturist: \_\_\_\_\_

Reason for your visit here today: \_\_\_\_\_

Are you being treated for this condition by anyone else?  No  Yes If yes, who \_\_\_\_\_

Has this condition been diagnosed by a Medical Doctor?  No  Yes (Diagnosis) \_\_\_\_\_

How does this condition effect you? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Do you have any known or suspected allergies  No  Yes (List) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Gender:  Male  Female

Please List the Medications and Supplements you are currently taking:

Drug/Supplement	Reason for Taking	For how Long	Dose	Frequency
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Are you currently taking Coumadin/warfarin or heparin?  No  Yes

**LIFESTYLE**

Please include daily amount used within the past 2 months:

Tobacco: No Yes Amount: \_\_\_\_\_ Alcohol: No Yes Amount: \_\_\_\_\_ Coffee No Yes Amount: \_\_\_\_\_

Recreational Drugs: No Yes Amount: \_\_\_\_\_ Daily water intake: \_\_\_\_\_ Daily soda intake: \_\_\_\_\_

Are you a vegetarian or vegan? No Yes Hours of sleep/night: \_\_\_\_\_

How would you rate the following areas of your health in the past month:

Energy: Great Good Fair Poor Comments: \_\_\_\_\_  
Digestion: Great Good Fair Poor Comments: \_\_\_\_\_  
Urination: Great Good Fair Poor Comments: \_\_\_\_\_  
Bowel movements Great Good Fair Poor Comments: \_\_\_\_\_  
Sleep: Great Good Fair Poor Comments: \_\_\_\_\_  
Appetite: Great Good Fair Poor Comments: \_\_\_\_\_

Typical day's meals:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Food Cravings: \_\_\_\_\_

Physical exercise you do regularly: \_\_\_\_\_

Hobbies or other recreation: \_\_\_\_\_

Hours of television watched per week: \_\_\_\_\_ Hours of work per week: \_\_\_\_\_

How do you feel about the following areas of your life in the past month:

Significant Other: Great Good Fair Poor N/A Comments: \_\_\_\_\_

Family: Great Good Fair Poor N/A Comments: \_\_\_\_\_

Diet: Great Good Fair Poor N/A Comments: \_\_\_\_\_

Sex Life: Great Good Fair Poor N/A Comments: \_\_\_\_\_

Self: Great Good Fair Poor N/A Comments: \_\_\_\_\_

Work: Great Good Fair Poor N/A Comments: \_\_\_\_\_

Exercise: Great Good Fair Poor N/A Comments: \_\_\_\_\_

How would you rate your current stress level? Extreme Very High High Moderate Low

How would you rate your energy level on a scale of 1-10? (10 being maximum) \_\_\_\_\_

**HEALTH INVENTORY**

Please check all that apply

<p><b><u>Head, Eye, Ear, Nose, Throat</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Impaired vision</li> <li><input type="checkbox"/> Eye pain/strain</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Glasses/contacts</li> <li><input type="checkbox"/> Tearing/dryness</li> <li><input type="checkbox"/> Floaters in eyes</li> <li><input type="checkbox"/> Impaired hearing</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Earaches/ear infections</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Nose bleeds</li> <li><input type="checkbox"/> Teeth grinding</li> <li><input type="checkbox"/> Frequent sore throats</li> <li><input type="checkbox"/> TMJ/jaw problems</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Other</li> </ul>	<p><b><u>Gastrointestinal</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stomach ulcers</li> <li><input type="checkbox"/> Changes in appetite</li> <li><input type="checkbox"/> Nausea/vomiting</li> <li><input type="checkbox"/> Epigastric/abdominal pain</li> <li><input type="checkbox"/> Passing gas</li> <li><input type="checkbox"/> Bloating</li> <li><input type="checkbox"/> Heart burn/acid reflux</li> <li><input type="checkbox"/> Belching</li> <li><input type="checkbox"/> Gall bladder disease/stones</li> <li><input type="checkbox"/> Colitis/diverticulitis</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Irritable bowl syndrome</li> <li><input type="checkbox"/> Leaky gut syndrome</li> <li><input type="checkbox"/> Other:</li> </ul> <p><b><u>Neurological</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vertigo/dizziness</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Numbness/tingling</li> <li><input type="checkbox"/> Loss of balance</li> <li><input type="checkbox"/> Seizure/epilepsy</li> <li><input type="checkbox"/> Dyslexia</li> </ul>	<p><b><u>Reproductive/Breasts</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Low libido</li> <li><input type="checkbox"/> Excessive libido</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Vaginal dryness</li> <li><input type="checkbox"/> Painful periods</li> <li><input type="checkbox"/> Clotting</li> <li><input type="checkbox"/> Heavy flow</li> <li><input type="checkbox"/> Scanty flow</li> <li><input type="checkbox"/> Bleeding between cycles</li> <li><input type="checkbox"/> Irregular cycles</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Menopausal symptoms</li> <li><input type="checkbox"/> Premenstrual problems</li> <li><input type="checkbox"/> Heavy cramping</li> <li><input type="checkbox"/> Endometriosis</li> <li><input type="checkbox"/> Fibroids</li> <li><input type="checkbox"/> Infertility</li> <li><input type="checkbox"/> Breast lumps/tenderness</li> <li><input type="checkbox"/> Fibrocystic breasts</li> <li><input type="checkbox"/> Nipple discharge</li> <li><input type="checkbox"/> Ovarian cysts</li> <li><input type="checkbox"/> Abnormal pap smear</li> <li><input type="checkbox"/> Hysterectomy</li> <li><input type="checkbox"/> Other</li> </ul>	<p><b><u>Musculoskeletal</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Neck pain</li> <li><input type="checkbox"/> Shoulder pain</li> <li><input type="checkbox"/> Muscle spasms/cramps</li> <li><input type="checkbox"/> Arm pain</li> <li><input type="checkbox"/> Upper back pain</li> <li><input type="checkbox"/> Middle back pain</li> <li><input type="checkbox"/> Lower back pain</li> <li><input type="checkbox"/> Leg pain</li> <li><input type="checkbox"/> Wrist/hand pain</li> <li><input type="checkbox"/> Elbow/arm pain</li> <li><input type="checkbox"/> Knee pain</li> <li><input type="checkbox"/> Foot/ankle pain</li> <li><input type="checkbox"/> Osteoporosis</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Joint pain</li> <li><input type="checkbox"/> Sciatica</li> <li><input type="checkbox"/> Scoliosis</li> <li><input type="checkbox"/> Other</li> </ul>
<p><b><u>Cardiovascular</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Heart disease</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Heaviness in the chest</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Edema</li> <li><input type="checkbox"/> I wear a pacemaker</li> <li><input type="checkbox"/> Other</li> </ul>	<p><b><u>Mental/Emotional</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Clinical depression</li> <li><input type="checkbox"/> Mild depression</li> <li><input type="checkbox"/> ADD or ADHD</li> <li><input type="checkbox"/> Schizophrenia</li> <li><input type="checkbox"/> Mood swings</li> <li><input type="checkbox"/> Panic attacks</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Alzheimer's</li> <li><input type="checkbox"/> Dementia</li> <li><input type="checkbox"/> Easily angered or agitated</li> </ul>	<p><b><u>Energy &amp; Immunity</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic fatigue syndrome</li> <li><input type="checkbox"/> General fatigue</li> <li><input type="checkbox"/> Slow wound healing</li> <li><input type="checkbox"/> Easy bruising</li> <li><input type="checkbox"/> Chronic infections</li> <li><input type="checkbox"/> Frequent allergies</li> <li><input type="checkbox"/> Fibromyalgia</li> <li><input type="checkbox"/> Lupus</li> <li><input type="checkbox"/> Other</li> </ul>	<p><b><u>Respiratory</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Frequent colds</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Other</li> </ul>
<p><b><u>Genito-Urinary Tract</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney disease</li> <li><input type="checkbox"/> Kidney stones</li> <li><input type="checkbox"/> Painful urination</li> <li><input type="checkbox"/> Dribbling urination</li> <li><input type="checkbox"/> Frequent UTI</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Other</li> </ul>	<p><b><u>Other</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Candida</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Rashes/Hives</li> <li><input type="checkbox"/> Eczema</li> <li><input type="checkbox"/> High Cholesterol</li> <li><input type="checkbox"/> Cold hands and feet</li> <li><input type="checkbox"/> Hemophilia</li> <li><input type="checkbox"/> Thin greying hair</li> <li><input type="checkbox"/> Insomnia</li> </ul>	<p><b><u>Endocrine</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hypothyroid</li> <li><input type="checkbox"/> Hyperthyroid</li> <li><input type="checkbox"/> Hypoglycemia</li> <li><input type="checkbox"/> Diabetes type I</li> <li><input type="checkbox"/> Diabetes type II</li> <li><input type="checkbox"/> Night sweats</li> <li><input type="checkbox"/> Unusual sweating</li> <li><input type="checkbox"/> Feeling hot or cold</li> <li><input type="checkbox"/> Other</li> </ul>	<p><b><u>Male Reproductive</u></b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Impotence</li> <li><input type="checkbox"/> Vasectomy</li> <li><input type="checkbox"/> Prostate problems</li> <li><input type="checkbox"/> Testicular pain/redness swelling</li> <li><input type="checkbox"/> Low libido</li> <li><input type="checkbox"/> Excessive libido</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Seminal emissions</li> <li><input type="checkbox"/> Other</li> </ul>

**Women Only:**

Are you pregnant right now No Yes Maybe Trying Method of birth control: \_\_\_\_\_

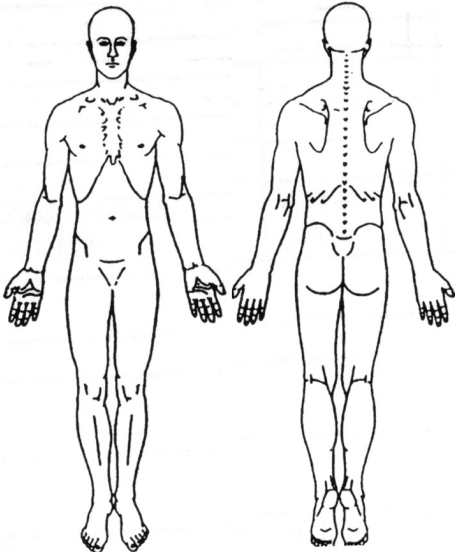
Age at first period: \_\_\_\_\_ Date of last menses: \_\_\_\_\_ Age at menopause: \_\_\_\_\_

Typical length of menses (days): \_\_\_\_\_ Typical length of cycle (from 1st day to 1st day of menses): \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Births: \_\_\_\_\_ Abortions: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

**PAIN**

**Please answer the following questions if you have pain.  
Indicate on the diagram on the left the areas of pain.**



Quality of pain:  Dull  Sharp  Stabbing  Sore  Cramping  Burning  
 Constant  Fixed  Moves about

On a scale of 1-10 (10 being worst) how strong is your pain? \_\_\_\_\_

Does the pain radiate?  No  Yes Where? \_\_\_\_\_

What helps the pain?  Ice  Heat  Rest  Movement  Pressure.  Moisture  
 Massage  Nothing.  Other \_\_\_\_\_

What aggravates the pain?  Ice  Heat  Rest  Movement  Pressure  
 Moisture  Massage  Nothing  Other \_\_\_\_\_

Do any medications help your pain? \_\_\_\_\_

Other treatments you have had for your pain: \_\_\_\_\_

Describe the onset of your pain: \_\_\_\_\_

Is there anything you wish to add? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about Harmony and Health Acupuncture?  Web Site  A Presentation

Referred by: \_\_\_\_\_  Other: \_\_\_\_\_

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Harmony and Health Acupuncture and Herbal Medicine 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if applicable): \_\_\_\_\_