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Welcome to Morningside Acupuncture and Natural Medicine

Please note that all information is strictly confidential.

Name

Date of Birth (MM/DD/YR) Age:

☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed

Address City State Zip

Home Phone Work Phone

Email Address Cell Phone

May we correspond with you (invoices, questions, etc) via email? ☐ Yes ☐ No

If not, how shall we best correspond with you?

Occupation Name of Company

Emergency Contact

Relationship Phone

Family Physician Phone

How did you hear about us?

Reason for today's visit:

What is the reason for your visit today?

How, when and where did this condition begin?

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Reason for visit, *continued:*

What types of treatments have you tried, if any?

How does this condition impair your daily activities?

What makes it better or worse?

Please list your main health problems that you would like to be free of in order of importance:

1

2

3

Your medical history:

Surgeries, Major Illnesses, Hospitalizations, Falls and Major Accidents (include dates)

Any birth trauma that you know of?

Family History

Health and major emotional states as a child:

List any major health issues in your family (going back to grandparents)

History of Abuse: (check if applicable) ☐ physical ☐ emotional ☐ sexual ☐ other

☐ Substance Abuse ☐ Suicide ☐ Other trauma

Please list any medications/vitamins/supplements you are currently taking

Medications Reason When &For how long

Herb/Medication allergies and reaction (if any)

Do you have, or have you ever had any of the following illnesses?

- ☐ Mental Illness
- ☐ Diabetes
- ☐ Hepatitis
- ☐ HIV+
- ☐ Seizures
- ☐ Cancer
- ☐ Heart Disease
- ☐ Asthma
- ☐ Allergies
- ☐ Stroke
- ☐ Arthritis
- ☐ Ulcers
- ☐ High Blood Pressure
- ☐ Venereal Disease
- ☐ Osteoporosis
- ☐ AIDS
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Mononucleosis
- ☐ Gall Stones
- ☐ Herpes
- ☐ Kidney Stones
- ☐ Chronic Fatigue
- ☐ Parasites
- ☐ Other

Lifestyle:

On a scale of 1 to 10 how good do you feel your nutrition is?
(1 worst /10 best)

Typical Breakfast: 1 2 3 4 5 6 7 8 9 10

Lunch: 1 2 3 4 5 6 7 8 9 10

Dinner: 1 2 3 4 5 6 7 8 9 10

Snacks: 1 2 3 4 5 6 7 8 9 10

Worst food in your diet?

What foods do you crave?

Water intake per day:

Caffeine (what form & how much)

Do you use tobacco? ☐ Yes ☐ No How much?

Alcohol? ☐ Yes ☐ No How much?

Work:

Do you enjoy your work? ☐ Yes ☐ No Number of hours per week working:

Exercise:

Do you exercise? ☐ Yes ☐ No Number of times per week:

Type of exercise:

Sleep:

Do you have trouble falling asleep? ☐ Yes ☐ No

Time to bed: Time to rise:

How many hours of sleep do you get per night?

Are you rested in the morning? ☐ Yes ☐ No

Do you wake in the night? ☐ Yes ☐ No

How is your home environment?

Describe any stress occurring at this time:

What are some hobbies/activities that provide you with a sense of pleasure and accomplishment?

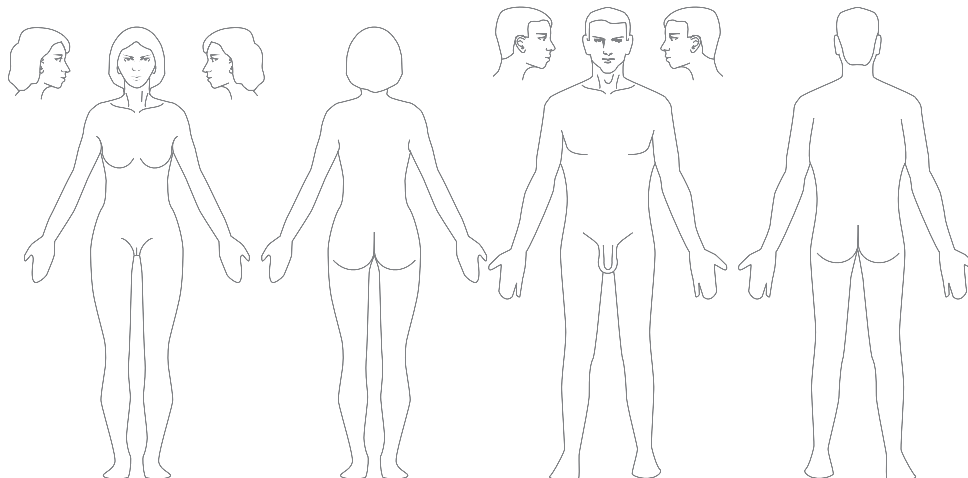
How much time do you make for these activities?

What is your opinion of yourself?

What is the most negative emotion you experience?

When and where?

Please mark all areas of pain on the diagram:



Notes:

Urination:

Please check any of the following symptoms you are currently experiencing:

☐ Burning ☐ Urgent ☐ Retention ☐ Scanty

☐ Profuse ☐ Dribbling ☐ Greater than 1x a night

Notes:

Bowel Movements

Frequency:

Feels complete? ☐ Yes ☐ No

Painful? ☐ Yes ☐ No

Consistency: ☐ Hard ☐ Loose ☐ Alternates

☐ Blood ☐ Mucus ☐ Well-formed

☐ Float ☐ Sink ☐ Undigested food

Men Only:

Have you been diagnosed with prostate problems? ☐ Yes ☐ No

Do you experience premature ejaculation? ☐ Yes ☐ No

Do you have problems with impotence? ☐ Yes ☐ No

Have you been diagnosed with infertility? ☐ Yes ☐ No

Diseases/Disorders:

Women Only:

At what age did you get your first period?

What was that like?

Date of last menstrual cycle:

Are you currently using contraception? ☐ Yes ☐ No

How long have you used contraception throughout your life?

Dates/Type:

Are you pregnant now? ☐ Yes ☐ No

Due Date?

How many pregnancies have you had?

Number of deliveries: Dates:

Terminations: When? Complications?

Miscarriages: When? Complications?

Maternal Family History of (please check):

☐ Infertility ☐ Fibroids ☐ Endometriosis

☐ PMS Menopause ☐ Menstrual Problems

☐ Cancer (type)

Medications your mother took when she was pregnant with you (if any)

Number of days from the start of one period to the start of the next:

Are your menstrual cycles spaced regularly? ☐ Yes ☐ No

Average number of days of flow:

Flow is: ☐ Light ☐ Normal ☐ Heavy

Color is: ☐ Pale ☐ Normal ☐ Dark ☐ Brown ☐ Bright Red

Are blood clots present? ☐ Yes ☐ No

Does your period cause you pain or cramping? ☐ Yes ☐ No

When? ☐ Before ☐ During ☐ After Period

Do you get nausea or vomiting with your period? ☐ Yes ☐ No

When? ☐ Before ☐ During ☐ After Period

Do you experience any of the following before your period each month?

☐ Water retention ☐ Migraines ☐ Mental depression

☐ Irritability ☐ Food cravings ☐ Breast tenderness or swelling

☐ Other

Do you ever bleed or spot between periods? ☐ Yes ☐ No

Do your bowel movements become loose at the beginning of your period? ☐ Yes ☐ No

Do you have any vaginal discharge between periods? ☐ Yes ☐ No

Color

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Do you have/have you ever had:

Abnormal pap smear? ☐ Yes ☐ No

When/Why?

A cervical biopsy/operation/ cauterization/conization? ☐ Yes ☐ No

Yeast infections? ☐ Yes ☐ No

Uterine fibroids or polyps? ☐ Yes ☐ No

Endometriosis? ☐ Yes ☐ No

Varicose veins? ☐ Yes ☐ No

Incompetent cervix? ☐ Yes ☐ No

Painful intercourse? ☐ Yes ☐ No

Sore heels when walking? ☐ Yes ☐ No

Numb legs/feet when standing still? ☐ Yes ☐ No

Pelvic inflammatory disease? ☐ Yes ☐ No

Incompetent cervix? ☐ Yes ☐ No

Difficulty experiencing orgasm? ☐ Yes ☐ No

Were you treated for it? ☐ Yes ☐ No

How

Date of last pap smear?

Have you been diagnosed with pelvic adhesions? ☐ Yes ☐ No

Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you experienced menopause? ☐ Yes ☐ No

When?

If you are experiencing menopausal symptoms, please describe:

Body Systems Review:

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0 1 2 3 4 low appetite
0 1 2 3 4 ravenous appetite
0 1 2 3 4 loose stools
0 1 2 3 4 heartburn/acid reflux
0 1 2 3 4 mouth sores
0 1 2 3 4 fatigue after eating
0 1 2 3 4 abdominal gas/bloating after food
0 1 2 3 4 bruise easily
0 1 2 3 4 gums (bleeding/swollen)
0 1 2 3 4 thirst
0 1 2 3 4 organ prolapsed (diagnosed)
0 1 2 3 4 belching or vomiting
0 1 2 3 4 spontaneous sweat
0 1 2 3 4 fatigue
0 1 2 3 4 allergies
0 1 2 3 4 catch colds easily
0 1 2 3 4 asthma
0 1 2 3 4 shortness of breath
0 1 2 3 4 general weakness
0 1 2 3 4 cough
0 1 2 3 4 dry nose/mouth/skin/throat
0 1 2 3 4 nasal discharge
0 1 2 3 4 feel worse after exercise
0 1 2 3 4 sinus congestion
0 1 2 3 4 sore, cold or weak knees
0 1 2 3 4 feel cold (in core)
0 1 2 3 4 low back pain
0 1 2 3 4 cold hands &/or feet
0 1 2 3 4 frequent urination
0 1 2 3 4 urinary incontinence
0 1 2 3 4 early morning diarrhea

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0 1 2 3 4	hearing loss
0 1 2 3 4	edema
0 1 2 3 4	face flushes
0 1 2 3 4	muscle spasms/twitches
0 1 2 3 4	irritable
0 1 2 3 4	feel better after exercise
0 1 2 3 4	numb extremities
0 1 2 3 4	tight feeling in chest
0 1 2 3 4	dry eyes
0 1 2 3 4	alternating diarrhea/constipation
0 1 2 3 4	ear ringing
0 1 2 3 4	symptoms worse with stress
0 1 2 3 4	anger easily
0 1 2 3 4	neck/shoulder tension
0 1 2 3 4	red eyes
0 1 2 3 4	feel heart beating
0 1 2 3 4	chest pain
0 1 2 3 4	insomnia
0 1 2 3 4	disturbing dreams
0 1 2 3 4	sores on tip of tongue
0 1 2 3 4	headaches
0 1 2 3 4	anxiety
0 1 2 3 4	restlessness
0 1 2 3 4	chest pain traveling to shoulder
0 1 2 3 4	see floaters in eyes
0 1 2 3 4	foggy thinking
0 1 2 3 4	heat in palms or soles
0 1 2 3 4	dizzy upon standing
0 1 2 3 4	feeling of heaviness
0 1 2 3 4	nausea
0 1 2 3 4	afternoon fever
0 1 2 3 4	night sweats
0 1 2 3 4	enlarged lymph node
0 1 2 3 4	cloudy urine

Libido	☐ high	☐ normal	☐ low
Overall body temperature	☐ high	☐ normal	☐ low
Overall energy level	☐ high	☐ normal	☐ low
Hair loss	☐ Yes	☐ No	
Impaired memory	☐ Yes	☐ No	

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Please sign below,

☐ I agree to authorize the practitioners of Morningside Acupuncture and Natural Medicine to provide care. I understand that care is provided by a multi-specialty approach – acupuncture, acupressure, massage, moxibustion, exercise, herbal and dietary therapies.

Fee Schedule: $115 initial visit
$85 return, breech or induction
$125 facial rejuvenation visit

Patient Signature

Date