Rejuvenate!! Center

Confidential Client Information Sheet

Patient Information

Name_____ Date_____

Address_____ City_____ State_____

Zip_____ Home phone_____ Work phone_____ Cell_____

Email_____ Have you had acupuncture before? ☐Yes ☐No

Height_____ Weight_____ Age_____ Sex**:** ☐Male ☐Female Date of birth_____

Occupation_____ Employer_____

In emergency notify (name):_____ Emergency phone number_____

Marital Status: ☐Single ☐Married ☐Domestic Partner ☐Divorced ☐Widowed ☐Separated

Number of children:_____ Ages of children:_____ Number who live with you:_____

Others living with you:_____

Primary Care Doctor_____ Last seen:_____

How did you hear about Acupuncture: ☐Yellow Pages ☐New Vision Ad ☐Article ☐A Talk

☐Brochure ☐Business Card ☐Web site ☐New Times Ad ☐Referred by:_____

Medical history

Reason for your visit here today:_____

_____

Are you being treated for this condition by anyone else: ☐Yes ☐No

If Yes, who? _____ Phone number:_____

Has this condition been diagnosed by a MD? ☐No ☐Yes Diagnosis:_____

Have these treatments helped? ☐Yes ☐Somewhat ☐Not much ☐Not at all

How does this condition affect you?_____

How long have you had this condition?_____

Do you currently have any infectious diseases? ☐Yes ☐No ☐Possibly

If Yes, please identify: ☐HIV ☐Hepatitis B ☐Hepatitis C ☐Flu/Cold ☐Streptococcus

☐Mononucleosis ☐Tuberculosis ☐Other:_____

Known or suspected allergies:_____

Childhood diseases you have had: ☐Chicken Pox ☐Measles ☐Mumps ☐Rheumatic Fever

☐Diphtheria ☐Scarlet Fever ☐Other_____

Accidents/Hospitalizations/Surgeries in the past 10 years:

Reason Date/Year(s)

_____

_____

_____

_____

_____

Your general health as a child: ☐Excellent ☐Good ☐Average ☐Poor

Health Inventory

Cardiovascular Conditions	**Emotional/Mental**	**Energy & Immunity**	**Respiratory**
☐ Heart Disease	☐ Clinical Depression	☐ Chronic Fatigue Syndrome	☐ Pneumonia
☐ A Pacemaker	☐ Mild Depression	☐ General Fatigue	☐ Asthma
☐ High Blood Pressure	☐ ADD or ADHD	☐ Slow Wound Healing	☐ Frequent Common Colds
☐ Low Blood Pressure	☐ Schizophrenia	☐ Easy Bruising	☐ Difficulty Breathing
☐ Chest Pain	☐ Mood Swings	☐ Chronic Infections	☐ Emphysema
☐ Palpitations	☐ Panic Attacks	☐ Frequent Allergies	☐ Persistent Cough
☐ Stroke	☐ Nervousness		☐ Pleurisy
☐ Varicose Veins	☐ Anxiety		☐ Tuberculosis
☐ Edema	☐ Alzheimer's		☐ Shortness of Breath
	☐ Dementia		

Musculo-Skeletal	**Head, Eye, Ear, Nose & Throat**	**Genital-Urinary Tract**	**Gastrointestinal**
☐ Neck/Shoulder Pain	☐ Impaired Vision	☐ Painful Urination	☐ Stomach Ulcers
☐ Muscle Spasms /Cramps	☐ Eye Pain/Strain	☐ Dribbling Urination	☐ Changes in Appetite
☐ Arm Pain	☐ Glaucoma	☐ Frequent UTI	☐ Nausea/Vomiting
☐ Upper Back Pain	☐ Glasses/Contacts	☐ Frequent Urination	☐ Epigastric/Abdominal Pain
☐ Mid Back Pain	☐ Tearing/Dryness	☐ Blood in Urine	☐ Passing Gas
☐ Low Back Pain	☐ Impaired Hearing	☐ Discharge	☐ Heart Burn
☐ Leg Pain	☐ Ear Ringing	☐ Incontinence	☐ Belching
☐ Osteoporosis	☐ Earaches		☐ Gall Bladder Disease
☐ Arthritis	☐ Ear Infections	**Neurological**	☐ Gall Bladder Stones
☐ Joint Pain	☐ Headaches	☐ Vertigo/Dizziness	☐ Hemorrhoids
	☐ Sinus Problems	☐ Paralysis	☐ Constipation
	☐ Nose Bleeds	☐ Numbness/Tingling	☐ Diarrhea
	☐Teeth Grinding	☐ Loss of Balance	
	☐ Frequent Sore Throats	☐ Seizures/Epilepsy	
	☐ TMJ/Jaw Problems	☐ Dyslexia	
	☐ Hay Fever		

Endocrine	**Other**	**Liver Conditions**	**Men Only**
☐Hypothyroid	☐ Cancer Type:_____	☐ Hepatitis A	☐ Impotence
☐ Hypoglycemia	☐ Fibromyalgia	☐ Hepatitis B	☐ Vasectomy Date_____
☐ Hyperthyroid	☐ Lupus	☐ Hepatitis C	☐ Prostate problems
☐ Diabetes Type I	☐ Candida		☐ Testicular Pain/ Redness/Swelling
☐ Diabetes Type II	☐ Anemia		☐ Low libido
☐ Night Sweats	☐ Rashes		☐ Excessive libido
☐ Unusual Sweating	☐ Eczema/Hives		☐ Painful Intercourse
☐ Feeling Hot or Cold	☐ Cold Hand/Feet		☐ Seminal emissions
	☐ Hemophilia		
	☐ Thin/Graying hair		

Women Only

Are you pregnant right now? ☐Yes ☐No ☐Trying ☐Maybe 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:____

Hysterectomy: ☐Yes ☐No Date:_____

Check all that apply: ☐Low libido ☐Excessive libido ☐Painful intercourse ☐Clotting ☐Painful periods ☐Heavy Flow ☐Scanty Flow ☐Bleeding Between Cycles ☐Irregular Cycles ☐Vaginal discharge ☐Breast Lumps/Tenderness ☐Nipple Discharge ☐Infertility ☐Menopausal Symptoms ☐Premenstrual problems

Medications

Please list all prescription ad aver the corner medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs yon are currently taking:

Supplement	Reason for taking	Potency	Frequency

Lifestyle

(*Daily amours used within the past 2 months*)

Tobacco: ☐Yes ☐No Amount_____ Alcohol: ☐Yes ☐No Amount_____

Coffee: ☐Yes ☐No Amount_____ Recreational Drugs: ☐Yes ☐No Amount_____

Do you feel you are at or near your ideal weight? ☐Yes ☐No

Do you feel you have enough energy? ☐Yes ☐No Are you vegetarian or vegan? ☐Yes ☐No

Best time of day:_____ Worst time of day: _____

Favorite Season:_____ Hours of sleep / night_____

Do you feel rested after a nights sleep?_____ Do you remember your dreams?____

Typical day's meals:

Breakfast:_____

Lunch: _____

Dinner:_____

Snacks / Other:_____

Food cravings:_____

Religion or other spiritual practice:_____

Hobbies or other recreation:_____

What kind of physical exercise do you do regularly?_____

Hours of television watched per week?_____ Hours of work per week?_____

Highest level of education completed? ☐High School ☐Bachelors ☐Masters ☐Doctorate ☐ Other

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

Emotions Relationships

Number of biological Brothers:_____ Sisters:_____ Were you adopted? ☐Yes ☐No

Your place in the birth sequence #:_____

Did you feel safe and nurtured as a child? ☐Always ☐Usually ☐Sometimes ☐Never

What would you characterize as your predominate emotion right now? ☐Anxiety/Worry ☐Anger ☐Grief ☐Fear/Dread ☐Depression ☐Melancholy ☐Happiness ☐Contentment ☐Joy ☐Numbness/Apathy ☐Other:_____

Do you enjoy your work? ☐Yes ☐Usually ☐Sometimes ☐Rarely ☐No

Why or why not?_____

Do you love where you live? ☐Yes ☐Usually ☐Sometimes ☐Rarely ☐No

Why or why not?_____

Do you feel you have a higher purpose for your life? ☐Yes ☐Usually ☐Sometimes ☐Rarely ☐No

Do you feel safe in your current significant relationship(s)? ☐Always ☐Usually ☐Sometimes ☐Never

Do you feel nurtured in your current significant relationship(s)? ☐Always ☐Usually ☐Sometimes ☐Never Are you happy with your current significant relationship(s)? ☐Always ☐Usually ☐Sometimes ☐Never Are you satisfied with your sex life? ☐Yes ☐Usually ☐Sometimes ☐Rarely ☐No

If you were guaranteed of success and money and time were not obstacles, what would you like to do with your life?_____

_____

_____

Please feel free to express any concerns or thoughts you feel may be relevant to your health below: Use the diagram if desired.

_____

_____

_____

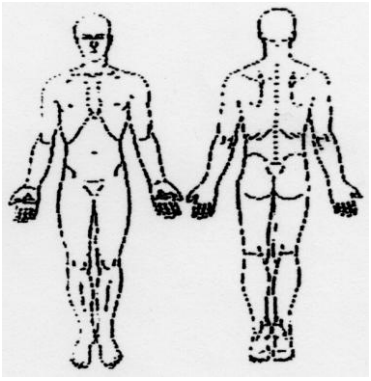
_____

_____

_____

_____

_____



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 *Rejuvenate!!Center ph 480-338-1012*, 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.

_____ _____

Signed Date

_____

Parent/Guardian(if applicable)