

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

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><u>Cardiovascular Conditions</u></p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema | <p><u>Emotional/Mental</u></p> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia | <p><u>Energy & Immunity</u></p> <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies | <p><u>Respiratory</u></p> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath |
| <p><u>Musculo-Skeletal</u></p> <input type="checkbox"/> Neck/Shoulder Pain <input type="checkbox"/> Muscle Spasms /Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain | <p><u>Head, Eye, Ear, Nose & Throat</u></p> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses/Contacts <input type="checkbox"/> Tearing/Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ/Jaw Problems <input type="checkbox"/> Hay Fever | <p><u>Genital-Urinary Tract</u></p> <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence <p><u>Neurological</u></p> <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Dyslexia | <p><u>Gastrointestinal</u></p> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Epigastric/Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea |
| <p><u>Endocrine</u></p> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold | <p><u>Other</u></p> <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema/Hives <input type="checkbox"/> Cold Hand/Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thin/Graying hair | <p><u>Liver Conditions</u></p> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C | <p><u>Men Only</u></p> <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date _____ <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain/ Redness/Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions |

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 and over the counter medications you are currently taking:

| Drug Name | Reason for taking | For how long | Dose | Frequency |
|-----------|-------------------|--------------|------|-----------|
|-----------|-------------------|--------------|------|-----------|

| | | | | |
|-------|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Please list all supplements and herbs you are currently taking:

| Supplement | Reason for taking | Potency | Frequency |
|------------|-------------------|---------|-----------|
|------------|-------------------|---------|-----------|

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Lifestyle

(Daily amounts 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 night's 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?_____

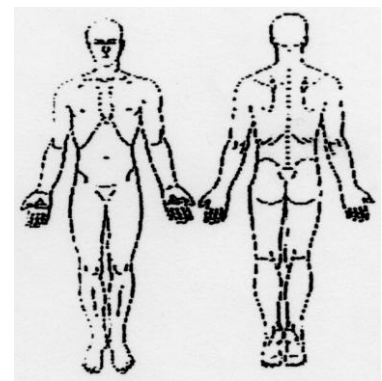
Do you feel you have a higher purpose for your life? Yes Usually Sometimes Rarely
No

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)