Sunflower Community Acupuncture Clinic

11749 North 75th St. Longmont, Co. 80503

720-684-8865

Patient Information

Date ______________________________

Name ______________________________

Address ______________________________

City, State, Zip ______________________

Age ________ Birthdate _______________

Occupation ___________________________

Primary Physician _____________________

How did you hear about us? _____________

____

Contact Information

Home Phone ___________________________

Work Phone ___________________________

Cell _________________________________

Email ________________________________
(we will never share your info)

> another person we may contact if needed:

Name ________________________________

Relationship __________________________

Home Phone ___________________________

Work Phone ___________________________

Health History

What are your primary reasons for treatment?

____

____

How is your Sleep? _____________________

____

How is your Digestion?__________________

____

What medications / supplements do you take?

____

____

List Serious Illnesses, Accidents, or Surgeries;

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Check Illnesses that have occurred in blood relatives:

❑ Diabetes ❑ High Blood Pressure ❑ Stroke

❑ Cancer ❑ Heart Disease ❑ Kidney Disease

Check symptoms you have had in the last year:

- ❑ Depression
- ❑ Difficulty with mental focusing
- ❑ Dizziness/
- ❑ Easily Startled
- ❑ Excessive Worry
- ❑ Excessive Anger
- ❑ Excessive Fear
- ❑ Fatigue / Tiredness/
- ❑ Headaches/
- ❑ Loss of Sleep / Poor Sleep
- ❑ Loss or Gain of Weight
- ❑ Nervousness / Irritability
- ❑ Overwhelmed by Life
- ❑ Environmental Sensitivities

Check conditions you have had in the past:

❑ AIDS	❑ Bleeding Disorders
❑ Allergies	❑ Breast Lump
❑ Anemia	❑ Cancer
❑ Arthritis	❑ Diabetes

How long has it been since your last medical exam?

____

____

Health History, continued

Check any symptoms you have had in the last year:

Muscle / Joint / Bones

- ❑ Tremors / Cramps
- ❑ Swollen Joints

Pain, Weakness, Numbness in:

- ❑ Arms
- ❑ Hips
- ❑ Back
- ❑ Legs
- ❑ Feet
- ❑ Neck
- ❑ Hands
- ❑ Shoulders

Eyes, Ear, Nose, Throat, Respiratory

- ❑ Asthma / Wheezing
- ❑ Blurred or Failed Vision
- ❑ Difficulty Breathing
- ❑ Earache
- ❑ Enlarged Glands
- ❑ Eye Pain
- ❑ Frequent Colds
- ❑ Hay Fever
- ❑ Hoarseness
- ❑ Gum Trouble
- ❑ Nose Bleeds
- ❑ Loss of Hearing
- ❑ Persistent Cough
- ❑ Ringing in Ears
- ❑ Sinus Problems

Skin

- ❑ Boils
- ❑ Bruise Easily
- ❑ Dry Skin
- ❑ Itching / Rash
- ❑ Sensitive Skin
- ❑ Sore that won't heal
- ❑ Sweats

Genito / Urinary

- ❑ Blood / Pus in Urine
- ❑ Frequent Urination
- ❑ Inability to control urine
- ❑ Kidney Infection / Stones
- ❑ Lowered Libido

Cardiovascular

- ❑ Chest Pain
- ❑ Hardening of the Arteries
- ❑ High or Low Blood Pressure
- ❑ Pain over Heart
- ❑ Poor Circulation
- ❑ Previous Heart Attack
- ❑ Rapid Irregular Heart Beat
- ❑ Swelling of Ankles

Gastrointestinal

- ❑ Belching, Gas or Bloating
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Difficulty Swallowing
- ❑ Distention of Abdomen
- ❑ Excessive Hunger
- ❑ Gall Bladder Trouble
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Pain Over Stomach
- ❑ Poor Appetite
- ❑ Vomiting

Please Check If Applicable

- ❑ Erection Difficulty
- ❑ Penis Discharge
- ❑ Prostate Trouble
- ❑ Bleeding Between Periods
- ❑ Clots in Menses
- ❑ Excessive Menstrual Flow
- ❑ Extreme Menstrual Pain
- ❑ Irregular Cycle
- ❑ Menopausal Symptoms
- ❑ PMS
- ❑ Previous Miscarriage
- ❑ Scanty Menstrual Flow

Could You Be Pregnant? ______________________

Do You Have Children?_______________________

Their Ages _________________________________

Please Sign Below, Thank You.

The information on this form is correct to the best of my knowledge.

Signature: ______________________________________ Date: ______ / ______ / ______