Gentle Path Acupuncture

Personal History Questionnaire

Patient Information Today's Date_____

Name: _____ Date of Birth_____

Age: _____ Male❑ Female❑

Address: _____City: _____State:_____Zip:_____

Home Phone: _____ Work or Cell Phone: _____

Email Address_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other_____

Your Occupation: _____ Your Employer_____

Referred to this office by: _____

Name of Insurance_____

Please Describe Present Major Health Concerns

Please Rate Your Symptoms (1-10 with 1 being least serious)

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Please list any Physicians you are currently seeing and the reason for their care:

_____

_____

Medical History

(Please mark the appropriate boxes)

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Concussion
- ❑ Convulsions
- ❑ Diabetes
- ❑ Dislocated joints
- ❑ Epilepsy
- ❑ German measles
- ❑ High blood pressure
- ❑ Multiple sclerosis
- ❑ Muscular Dystrophy
- ❑ Nervousness
- ❑ Polio
- ❑ Poor circulation
- ❑ Hepatitis
- ❑ Rheumatic fever
- ❑ Rheumatism
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Venereal Disease

Head

- ❑ Headaches
- ❑ Difficulty concentrating
- ❑ ADD/ ADHD
- ❑ Forgetful
- ❑ Head feels heavy
- ❑ Changes in hair
- ❑ Other_____ _____

Sinuses and Nose

- ❑ Sinus trouble
- ❑ Seasonal
- ❑ All year
- ❑ Runny Nose

Phlegm

- ❑ Clear
- ❑ White
- ❑ Yellow
- ❑ Green

- ❑ Other_____ _____

Eyes

- ❑ Itchy
- ❑ Watery
- ❑ Dry
- ❑ Tired
- ❑ Cataracts
- ❑ Getting weaker
- ❑ Other_____ _____

Ears

- ❑ Ringing in ears
- ❑ Ear infections
- ❑ Poor hearing
- ❑ Other_____ _____

Mouth

- ❑ Teeth problems
- ❑ Bleeding gums
- ❑ Bad breath
- ❑ Sore throat
- ❑ Jaw pain
- ❑ TMJ
- ❑ Other_____ _____

Neck

- ❑ Tension due to stress
- ❑ Pain
- ❑ Thyroid problems
- ❑ Swollen glands
- ❑ Other_____ _____

Shoulders

- ❑ Pain in joints
- ❑ Sore muscles
- ❑ Shoulder injury
- ❑ Decreased mobility
- ❑ Other_____ _____

Arms

Enter # on appropriate line

1. Upper arm
2. Elbow
3. Wrist
4. Hand
5. Fingers

____ Decreased Mobility
____ Pain
____ Numbness /tingling
____ Paralysis
____ Cold

- ❑ Other_____ _____

Chest

- ❑ Heart palpitations
- ❑ Pain in chest
- ❑ Heart skipping beats
- ❑ Heart condition
- ❑ High blood pressure
- ❑ Injury to chest
- ❑ Lung condition
- ❑ Asthma
- ❑ Shortness of breath
- ❑ Other_____ _____

Digestion

- ❑ Acid reflux
- ❑ Heartburn
- ❑ Food sits in stomach
- ❑ Excessive belching
- ❑ Excessive gas
- ❑ Irritable bowel syndrome
- ❑ Constipation
- ❑ Diarrhea
- ❑ Pain
- ❑ Other_____ _____

Urination

- ❑ Frequent urination
- ❑ Difficulty urinating
- ❑ Bladder does not fully empty
- ❑ Up at night to urinate _____times
- ❑ Urinary tract infections
- ❑ Bladder infections
- ❑ Other_____ _____

Reproductive Men

- ❑ Impotence
- ❑ Low desire
- ❑ Excessive desire
- ❑ Premature ejaculation
- ❑ Testicle pain
- ❑ Enlarged prostate
- ❑ Other_____ _____

Reproductive Women

- ❑ Menstruation every_____ days
- ❑ Irregular menstruation
- ❑ Heavy periods
- ❑ Light /scanty periods

Blood color

- ❑ Pink
- ❑ Bright red
- ❑ Dark red
- ❑ Purple
- ❑ Brown

- ❑ Clots
- ❑ Cramping
- ❑ Breast fibroids
- ❑ Uterine fibroids
- ❑ Cysts
- ❑ Infertility
- ❑ Pregnancies_____
- ❑ Live births _____
- ❑ Fertility treatment
- ❑ Low sexual desire

Other_____ _____

Back

- ❑ Back pain
- ❑ Upper
- ❑ Middle
- ❑ Low
- ❑ Radiates into hips
- ❑ Radiates into legs
- ❑ Down back of leg
- ❑ Back surgery
- ❑ Hip pain
- ❑ Other_____ _____

Legs

- ❑ Leg pain
- ❑ Knee pain
- ❑ Knee injury
- ❑ Varicose veins
- ❑ Calf pain
- ❑ Ankle pain
- ❑ Pain in foot
  - ❑ Heel
  - ❑ Arch
  - ❑ Ball of foot
  - ❑ Toes
- ❑ Cold Feet
- ❑ Other_____ _____

Emotional Well-being

Childhood

- ❑ Childhood Stress
- ❑ School Stress
- ❑ Family Stress
- ❑ Personal relationships
- ❑ Stress of being sick
- ❑ Abuse

Adulthood

- ❑ Work related stress
- ❑ Stress of commuting
- ❑ Loss of loved one
- ❑ Relationship stress
- ❑ Change in lifestyle
- ❑ Change in vocation
- ❑ Abuse

Grade your Mental Health

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Getting Better
- ❑ Getting Worse

Have you ever been hospitalized? ❑Yes ❑No If yes, what for? _____

Surgical History:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Diet -What did you eat for breakfast, lunch and dinner yesterday?

Breakfast	Lunch	Dinner	Snacks

Was this a typical day for you? _____Yes _____No

Do you consume alcohol? _____Yes _____ No If yes, how many times per week? _____

Do you consume caffeine? _____Yes _____ No If yes, how many times per week?_____

If you take herbal supplements, please list them:

_____

_____

Please list all medication you are currently taking:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Are you allergic to any foods or Medication? _____Yes _____No
If yes, please list? _____

Patients Signature: _____ Date_____

Gentle Path Acupuncture

500 Bishop Street
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Atlanta, Ga. 30318

Informed Consent for Acupuncture Treatment

This informed consent is a requirement of the State of Georgia under chapter 360-6.

This is to inform you that an Acupuncturist is not licensed to practice medicine in the State of Georgia; an Acupuncturist is not making a medical diagnosis of you disease or medical condition; if you want to obtain a medical diagnosis you should see a licensed Medical Doctor.

I understand that acupuncture involves placing sterilized, one-use disposable needles through the skin, into muscles near vessels, nerves and bones. My Acupuncturist may simply leave the needle in place, apply heat or manipulate them.

There are possible risks associated with this type of treatment that I accept but are not limited to bleeding, bruising and local swelling. I may also feel pain or minor discomfort at the site of the acupuncture point that has been stimulated.

The Acupuncturist will explain to you the nature and purpose of the acupuncture treatment.

This is your personal agreement to acknowledge these statements.

_____ _____

Patient Signature Date