Arcadia Women's Wellness

body | mind | chi

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender **M F T**	Date of Birth ____ / ____ / _____	Age	Marital Status:	Height:	Weight:

Street Address	City	State	Zip

Phone (Daytime) –	Phone (Nighttime)

OK to leave VM?	Place of Employment	Occupation

Name & Phone Numbers of Partner:	Name & Phone Number of Emergency Contact:

E-Mail: Preferred Pharmacy:
Do you want to receive e-newsletter? Y / N

How did you hear about us? *Please circle one and write the name*

Current Patient: _____ Doctor: _____Advertisement: _____

Friend: _____Website: _____ Other:_____

Have you received a diagnosis for your condition(s)? Y / N If so what:: By whom:	Have you had Acupuncture before? Y / N

Chief Concerns/Goals
(be specific)

_____

_____

_____

_____

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_____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed, including pychological.

Year **Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES Please list medication, environmental, & food allergies and reaction

_____

_____

_____

_____

LIFESTYLE

Exercise (activity, duration, & frequency: _____

Diet: Food avoidances/sensitivities: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Caffeine (frequency/amount): _____

*Alcohol (frequency/amount): _____

Water (frequency/amount): _____

*Nicotine (current/past, amount, duration): _____

*Recreational Drugs (type, frequency): _____

***Fertility patients only: please provide information re: partner's usage**

FAMILY MEDICAL HISTORY (please list any cardiovascular disease, cancer, diabetes, autoimmune conditions or fertility issues)

_____

_____

_____

REVIEW OF SYSTEMS (Please check all that apply, circle where appropriate)

Psych/Head/Ears/Eyes/Nose/Throat:

_____ Headaches/Migraines _____ Anxiety/depression _____ Insomnia

_____ Vision change/blurriness _____ Hoarse/sore throat _____ Allergies

_____ Hearing/ringing in ears _____ Concentration/memory

_____ Difficulty swallowing _____ Other _____

Cardiopulmonary:

_____ Chest pain _____ Palpitations _____ Asthma

_____ High blood pressure _____ Blood clots _____ High cholesterol

_____ Xray/US/EKG/Stress test _____Shortness of breath

_____ Other: _____

Hair/Skin:

_____ Dryness/itching/rash _____ Acne _____Bruising

_____ Hair loss _____ Hair growth _____ Discoloration

_____ Abnormal growths _____ Other _____

Gastrointestinal:

_____ Diarrhea _____ Gas/bloating _____ Abdominal pain

_____ Blood/mucus in stool _____ Constipation _ _____ Reflux/heartburn

_____ Nausea/vomiting _____ Colonoscopy/endoscopy/US

_____ Other: _____

Musculoskeletal:

_____ Neck pain/stiffness _____ Joint pain/swelling, which _____

_____ Back pain/stiffness _____ Weakness/numbness

_____ Other: _____

GYNECOLOGIC HISTORY (skip any that doesn't apply)

Age 1st menses _____ Early symptoms, hormone use: _____

Pregnancy # _____ Birth # _____ Miscarriage # _____ Abortion # _____ Adoption # _____

Dates of above: _____

Complications/birth trauma: _____

Last menses: _____Ave. cycle days _____ Ave. menses days _____ Past menses: _____

Sexually active? _____ Hetero/Homo/Bi-sexual? Possible current pregnancy? _____

Fertility issues (duration/treatments tried/where): _____

_____

GYN surgeries/imaging (what/when)_____

Contraception use: Present type/duration: _____

Past types/duration: _____

Last pap/HPV _____ History abnormal? _____

Last mammogram/US _____ History abnormal?_____

Last colonoscopy _____ History abnormal? _____

Menopausal? ___ Natural ___ Surgical (procedure/date) _____

___ Post-menopausal bleeding

___ Hormone use (type/duration) _____

Hormonal Symptoms:

____ Mood issues (PMS/postpartum/menopausal), specify _____

____ Heavy bleeding ____ Irregular bleeding ____ Clots

____ Skipped menses ____ Painful menses ____ Endometriosis

____ Headaches ____ Hot flashes ____ Ovarian cysts

____ PMS symptoms/duration: _____

____Libido/sexual function ____ Breast pain/cysts ____ Osteoporosis

____ Vaginal/urinary tract infections ____ Nipple discharge

____ Vaginal dryness/pain with intercourse ____ Other _____

MEDICATIONS/SUPPLEMENTS (Please list & include dosage/frequency/purpose)

_____

_____

_____

_____

_____

_____

_____

_____

_____

VACCINATIONS (Please list & include date, and note if you are currently due)

Influenza: _____

Pnemoccocal: _____

Shingles: _____

Human PapilomaVirus:_____

Varicella: _____

Hepatitis A or B: _____

Other: _____

WHAT HAVEN'T I ASKED THAT YOU WOULD LIKE TO SHARE?

_____

_____

_____

_____

_____

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_____

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_____