EARTH MOON ACUPUNCTURE
HEALING FROM THE GROUND UP

NAME _____

DOB _____

GENERAL PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method (circle two): ☐ **Home** ☐ **Cell** ☐ **Text** ☐ **Email**

Age: _____ Date of Birth: _____ Place of Birth: _____

Occupation: _____ Employer: _____

Guardian & Phone (if under 18): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Name & ID: _____

General Physician & Phone Number: _____

Reason & Date of Last Dr. Appointment: _____

Permission to Contact (Signature): _____

How did you hear about us? _____

Wendy Childs, L.Ac. • Michelle Denker, L.Ac. • Sequoia Arayas, L.Ac.
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FAMILY HEALTH HISTORY

Please fill out the table below with information about your family (or adoptive familys) health history.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Please list any diseases or ailments impacting your family below:

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PERSONAL HEALTH HISTORY

Name: _____ DOB: _____

Gender: _____ Height: _____ Weight: _____ Blood Type: _____ BP: _____

SYMPTOMS CHECK SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfullness
- ☐ Headache
- ☐ Loss Of Sleep
- ☐ Loss Of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscles/Joints/Bones
- ☐ Arms/Hands
- ☐ Back
- ☐ Feet/Legs
- ☐ Hips
- ☐ Neck
- ☐ Shoulders

Genito-Urinary
- ☐ Blood In Urine
- ☐ Frequent Urination
- ☐ Lack Of Bladder Control
- ☐ Painful Urination

Gastrointestinal
- ☐ Appetite
- ☐ Bloating
- ☐ Bloating/Belching/Gas
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach/Abdominal Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling Of Ankles
- ☐ Varicose Vains

Eye, Ear, Nose & Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss Of Hearing
- ☐ Nose Bleeds
- ☐ Persistent Cough
- ☐ Ringing In Ears
- ☐ Sinus Problems
- ☐ Vision Flashes
- ☐ Vision Halos

Skin
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Changes In Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore That Wont Heal
- ☐ Psorasis

Men Only
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump In Testicles
- ☐ Penis Discharge
- ☐ Sore On Penis
- ☐ Other Male Issue

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other Female Issue

Last Menstrual Period:

Last Pap Smear:

Had a Mammogram?

Could You Be Pregnant?

Number of Children?

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PERSONAL HEALTH HISTORY CONTINUED

CONDITIONS CHECK CONDITIONS YOU HAVE, OR HAVE HAD IN THE PAST.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Concussion
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hemia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problem
- ☐ Tonsillitis
- ☐ Traumatic Head Injury
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Weight Gain/Loss

Have you had any hospitalizations, births, accidents or injuries? Please list them below.

Year/Age	What Was Wrong	What Was the Outcome

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VISIT DETAILS

Main Complaint: _____

When Did It Start: _____ How Often Does It Happen: _____

What makes it better? What makes it worse? How severe is it?

Severity Level

< Low Extreme >

Secondary Complaint: _____

When Did It Start: _____ How Often Does It Happen: _____

What makes it better? What makes it worse? How severe is it?

Severity Level

< Low Extreme >

Health Habits

Please list any health habits you have, and how often:

- ☐ Caffeine _____
- ☐ Tobacco _____
- ☐ Drugs _____
- ☐ Alcohol _____

Medications

Please list any medications you're taking.

Work Concerns

Please list any occupational concerns you have below:

- ☐ Heavy Lifting _____
- ☐ Stress _____
- ☐ Hazardous Substance Exposure _____

Allergies

Please list any allergies you have.

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PAIN INFORMATION

Please circle which descriptions describe your current pain levels most accurately.

Pain Intensity

- The pain comes and goes and is very mild
- The pain is mild and does not vary much
- The pain comes and goes and is moderate
- The pain is moderate but does not vary
- The pain comes and goes and is very severe
- The pain is very severe and does not vary much

Sleeping

- I get no pain in bed
- I get pain in bed but I can sleep well
- My sleep is reduced by less than 25%
- My sleep is reduced by less than 50%
- My sleep is reduced by less than 75%
- Pain prevents me from sleeping at all

Lifting

- I can lift weights without pain
- I can lift weights but it causes pain
- I can't lift weights off the floor

Standing

- I can stand as long as I want with no pain
- I have pain standing, but time doesn't effect it
- I can't stand longer than an hour
- I can't stand longer than a half hour
- I can't stand longer than 10 minutes
- I get pain upon standing

Walking

- I have no pain when walking
- I have pain walking, but distance doesn't effect it
- I cannot walk farther than a mile
- I cannot walk farther than a half mile
- I cannot walk farther than a quarter mile
- I can't walk without causing pain

Personal Care

- I don't change how I wash/dress to avoid pain
- Washing/dressing causes pain, but I still do both
- Because of pain, I can't wash/dress without help

Sitting

- I can sit in a chair as long as I want
- I can only sit in my favorite chair
- I can't sit longer than an hour
- I can't sit longer than a half hour
- I can't sit longer than 10 minutes
- I get pain upon sitting

Travelling

- I get no pain while travelling
- I get some pain while travelling
- I get a lot of pain from travelling
- Pain restricts my travel

Social Life

- My social life is normal with no extra pain
- My social life is normal but with pain
- Pain only effects energetic interests
- Pain restricts my social life, I avoid going out
- Pain restricts me to my home/no social life

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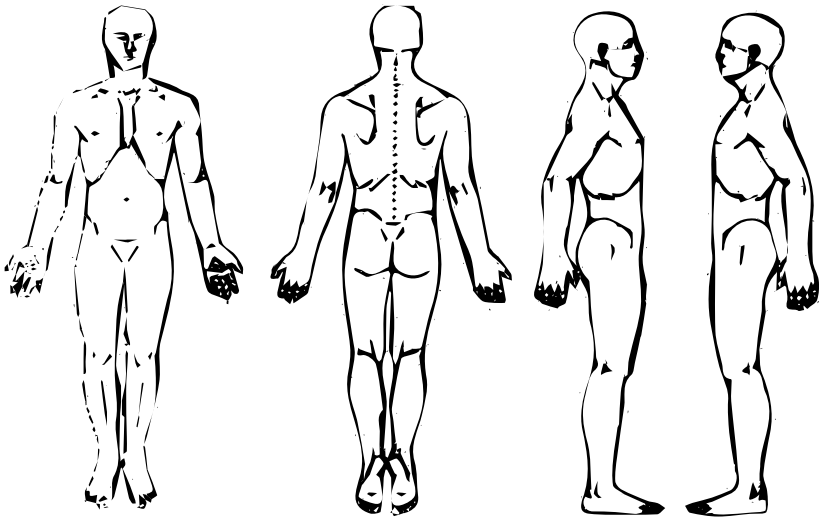

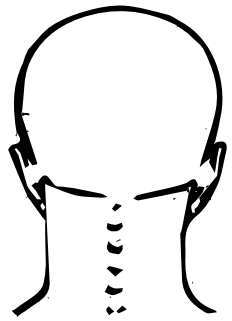

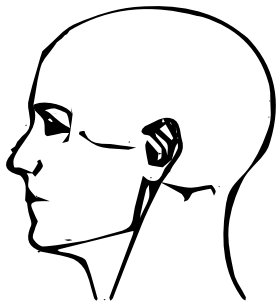

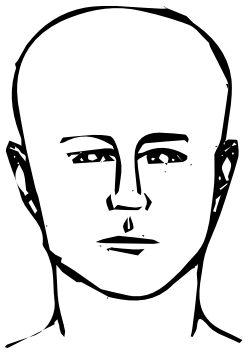

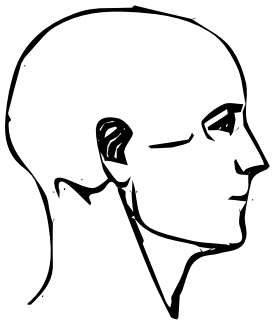

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