

INNERLIGHT HEALTH SPA

(845) 229-9998 - www.InnerLightHealthSpa.com

Acupuncture Client History Form

Name _____ Date _____ Telephone Number _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Would you like to receive the monthly InnerLight Bulb e-Newsletter? Yes No

How did you hear about us? (Please be specific) _____

Date of Birth ____/____/____ Height ____ Weight ____ Occupation _____

Activities or repetitive motions (occupational, recreational...etc.) _____

Primary reason for appointment _____

Have you ever received acupuncture before? Yes No

What are your primary concerns for coming in for treatment? _____

Have you seen a physician for these problems? Yes No

To what extent do these problems have for you?(work, sleep, digest...etc.) _____

List all medications and supplements you are taking: _____

Please check any conditions that you have, or have had in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Nervousness/irritability | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Overwhelmed by life | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Easily startled | <input type="checkbox"/> Cancer | Illnesses in blood relatives: |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Excessive fear | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Fatigue/tiredness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Insomnia/poor sleep | <input type="checkbox"/> Hepatitis/please circle: A,B,C | <input type="checkbox"/> Addictions |
| <input type="checkbox"/> Loss or gain in weight | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Mental Illness |

Please check any symptoms you have had in the past year:

For Men Only

- Testicular Pain
- Prostate Disease
- Penis Discharge

For Women Only

- Breast pain or tenderness
- Excessive / deficient menstrual bleeding
- Irregular cycle
- Menopause symptoms: Heat symptoms
- Dryness Other: _____
- PMS: Emotional before / during menses
- Cramps / Breast tenderness before / during menses Other: _____
- Previous miscarriage
- On birth control
- Number of pregnancies
- Number of live births

Are you pregnant now? Yes No

Lifestyle Habits

- Regular exercise Yes No
- Eat a balanced diet Yes No
- Enjoy my work / daily activities Yes No
- Good social and/or family network Yes No
- Enough downtime / able to relax Yes No
- Glasses of water you drink per day _____
- Use tobacco / How much? _____
- More than 1-2 alcoholic drinks per day?
- Use recreational drugs
- Daily habit of coffee/energy drinks/diet soda
- Food cravings
- Difficulties in my relationships

Genito/Urinary

- Blood / pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection / stones
- Lowered libido
- STD's
- Sexual difficulties
- Infertility

Cardiovascular

- Chest pain
- Hardening of arteries
- Poor circulation
- Previous heart attack
- Rapid / irregular heart beat
- Swelling of ankles

Gastrointestinal

- Belching, gas or bloating
- Constipation
- Difficulty swallowing
- Gall bladder disease
- Liver disease
- Jaundice
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Stomach pain
- Poor appetite

Muscles/Joints/Bones

- Tremors - where? _____
- Cramps - where? _____
- Swollen joints - where? _____
- Numbness - where? _____

Eyes/Ears/Nose/Throat/Respiratory

- Blurred or failing vision
- Difficulty breathing / asthma
- Difficulties with ears
- Difficulties with eyes
- Frequent colds
- Allergies
- Gum / tooth trouble
- TMJ / grinding
- Persistent cough
- Sinus problems

Skin

- Acne
- Bruise easily
- Itching / rash
- Sensitive skin
- Sore won't heal
- Sweats

Any other concerns: (List Below)