THE WRIGHT POINT, L.L.C.

Patient Information and Health History Form

Patient Name	Age	Date of Birth	Gender M ☐ F ☐
Street Address	City		State/Zip

Email Address	Telephone (HOME)	Telephone (WORK)	Best Number to Contact You

Emergency Contact Name	Relationship	Contact Telephone Number

Occupation	Years Attended High School	Years Attended College	Degrees

Current Health Care Providers

Primary Care Physician	**PCP Address**	**PCP Office Number**
Referring Physician	**Referring Physician Address**	**Referring Physician Office Number**

Please list other health care providers (massage therapists, physical therapists, naturopaths, etc.)

Practitioner Name	Office Number
Practitioner Name	Office Number
Practitioner Name	Office Number

Personal Medical History

Please check the following conditions that apply to you

	Alcoholism/Substance Abuse		German Measles		Measles
	Allergies		Glaucoma		Mononucleosis
	Anemia		Hearing Loss		Neuralgia/Neuritis
	Anxiety		Heart Disease		Osteoporosis/Osteopenia
	Arthritis		Heart Murmur/arrhythmia		Pancreatitis
	Asthma		Headaches		Pneumonia
	Blood Clots/Phlebitis		Hemorrhoids		Rheumatic Fever
	Cancer		Hepatitis		Seizures
	Type?		Hernia		Sexually Transmitted Disease
	Chicken Pox		High Blood Pressure		Scarlet Fever
	Depression		High Fever		Sinusitis
	Diabetes		High Cholesterol		Skin Disease
	Digestive Disorder -		History of Infertility		Stroke
	Type?		Hives or Rashes		Thyroid Disease
	Diverticulosis		Kidney Infections/Stones		Tuberculosis
	Eczema		Liver Disease		Urinary Incontinence
	Eye infections/disorders		Lung Disease		Urinary Tract Infection
	Gallbladder Disorder		Malaria		
	Other - List				

Please give additional information for any of the above checked illnesses on next page.

Additional Information

Hospitalizations and Surgeries

Operation or Illness	Year	Outcome

Family Medical History

	If Living, Age	**If Deceased, Age at death**	**Significant Medical History, i.e., Cancer, Heart Disease, Diabetes, Etc.,**
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings or Children Indicate relationship			

Please circle Y for yes or N for no for the following questions. Feel free to add comments to any in the margin or at the end.

1. Do you bruise easily? Y N
2. Do you ever faint or feel faint? Y N
3. Do you have any tingling or numbness? Y N
4. Do you have a tendency to shake or tremble? Y N
5. Do you have difficulty making decisions? Y N
6. Do you find it difficult to concentrate or remember things? Y N
7. Do you usually feel lonely or depressed? Y N
8. Would you say you have a hopeless outlook? Y N
9. Do you worry often? Y N
10. Do you have a strong dislike for criticism? Y N
11. Do you lose your temper often? Y N
12. Are you having any sexual difficulties? Y N
13. Have you ever considered suicide? Y N
14. Have you gained or lost more than 10 pounds in the last 6 months? Y N

15. Do you have a tendency to be too hot or too cold? Y N
16. Do you tend to startle easily? Y N
17. Do you have difficulty either falling asleep or staying asleep? Y N
18. Do you have two or more alcoholic beverages per day? Y N
19. Do you drink more than two cups/glasses of coffee, tea, or soda per day? Y N
20. Do you use recreational drugs? Y N
21. Do you ever have heartburn? Y N
22. Are you constipated more than twice per month? Y N
23. Are your bowel movements loose for more than one day? Y N
24. Are your bowel movements ever black or bloody? Y N
25. Do you have a constant feeling that you need to urinate? Y N
26. Is your urine stream weak and slow? Y N
27. Do you have hot flashes or night sweats?

Females only
Number of pregnancies? ________________________
Number of children born alive? ___________________
Have you ever had an abortion? ___________________

Medications
Please list your current medications. Include prescription and over the counter drugs.

Medication	Reason	Dosage	When Started

Supplements
What vitamins, herbs, nutritional supplements do you take?

Supplement	Reason	Dosage	When started

What are your specific functional goals for attending acupuncture treatment? In other words, if this is a successful treatment regimen how will your life be different? What will you be able to do that you cannot do now?

1. ____
2. ____
3. ____