CACTUS NEEDLE

Acupuncture & Energy Work

New Patient Paperwork

Contact Information

Legal Name:_____

(Last, First)

Do you have a preferred name? _____

Birth Date: _____ Age:_____

(MM/DD/YYYY)

Gender: _____ Pronouns: _____

Address: _____

(Street) (City/State/Zip)

Phone number: _____ Permission to leave message? *(circle one)* Yes No

Do you prefer to be called or texted? *(circle one)*

Email address: _____

Marital Status: *(circle one)* married single divorced separated widowed

domestic partnership

Employment Information

Employer Name: _____ Occupation: _____

Employer Address: _____

(Street) (City/State/Zip)

Emergency Contact(s) Information

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

CACTUS NEEDLE

Patient Name: _____ Date of Birth: _____

Current Health

Please ✔Check any of the following symptoms you have:

Head & Neck:
- ☐ Frequent Headaches
- ☐ Neck Pain
- ☐ Lumps or Swelling

Eyes:
- ☐ Glaucoma
- ☐ Blurry Vision
- ☐ Weakening Eyesight
- ☐ Double Vision
- ☐ Eye Pain or Itching
- ☐ Watering Eyes

Ears:
- ☐ Difficulty Hearing
- ☐ Earaches
- ☐ Running Ear(s) L R Both
- ☐ Buzzing or Ringing in Ear(s) L R Both
- ☐ Motion Sickness

Mouth:
- ☐ Dental Problems
- ☐ Sore Tongue
- ☐ Swelling of Gums or Jaw
- ☐ Taste Change

Nose & Throat:
- ☐ Congestion
- ☐ Running Nose
- ☐ Allergies
- ☐ Sore Throat
- ☐ Enlarged Tonsils
- ☐ Hoarse Voice
- ☐ Frequent Cold(s)

Skin:
- ☐ Chronic Skin Condition
- ☐ Rash
- ☐ Eczema or Excessive Itching
- ☐ Acne
- ☐ Jaundice

Cardiovascular:
- ☐ Palpitations
- ☐ Angina
- ☐ Heart Murmur
- ☐ Shortness of Breath w/ Activity
- ☐ High Blood Pressure
- ☐ Swelling of Feet / Ankle(s)

Musculoskeletal:
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Joint or Muscle Swelling
- ☐ Decreased Range of Motion

Neurological:
- ☐ Traumatic Brain Injury
- ☐ Vertigo
- ☐ Numbness or Tingling in Fingers / Toes
- ☐ Tremors or Seizures
- ☐ Lightheadedness

General:
- ☐ Loss of Appetite
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Dehydration
- ☐ Unexplainable Weight Loss or Gain

Gastrointestinal:
- ☐ Heartburn
- ☐ Difficulty Swallowing
- ☐ Bloating
- ☐ Belching
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stool Urgency
- ☐ Rectal Bleeding

Urogenital:
- ☐ Blood in Urine
- ☐ Nighttime Urgency
- ☐ Difficulty Urinating
- ☐ Burning during Urination
- ☐ Urinary Incontinence

Pulmonary:
- ☐ Chronic Cough
- ☐ Coughing up Blood
- ☐ Bronchitis
- ☐ Sleep Apnea
- ☐ Wheezing

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ ADHD
- ☐ Bipolar Disorder
- ☐ Schitzophrenia
- ☐ PTSD

Male Genital:
- ☐ Weak Urine Stream
- ☐ Prostate Problems
- ☐ Lumps or Masses on Testicles
- ☐ Discharge from Penis
- ☐ Painful or Swollen Testicles

Female Genital:
- ☐ Menstrual Problems
- ☐ Excessive Vaginal Bleeding
- ☐ Hot Flashes
- ☐ Breast Lump(s)
- ☐ Premenstrual Tension
- ☐ Last Menstrual Period:

- ☐ Last Pap Smear:_____

- ☐ Number of Pregnancies:_____

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Patient Name: _____ Date of Birth: _____

Do you now or have you in the past used any of the following?

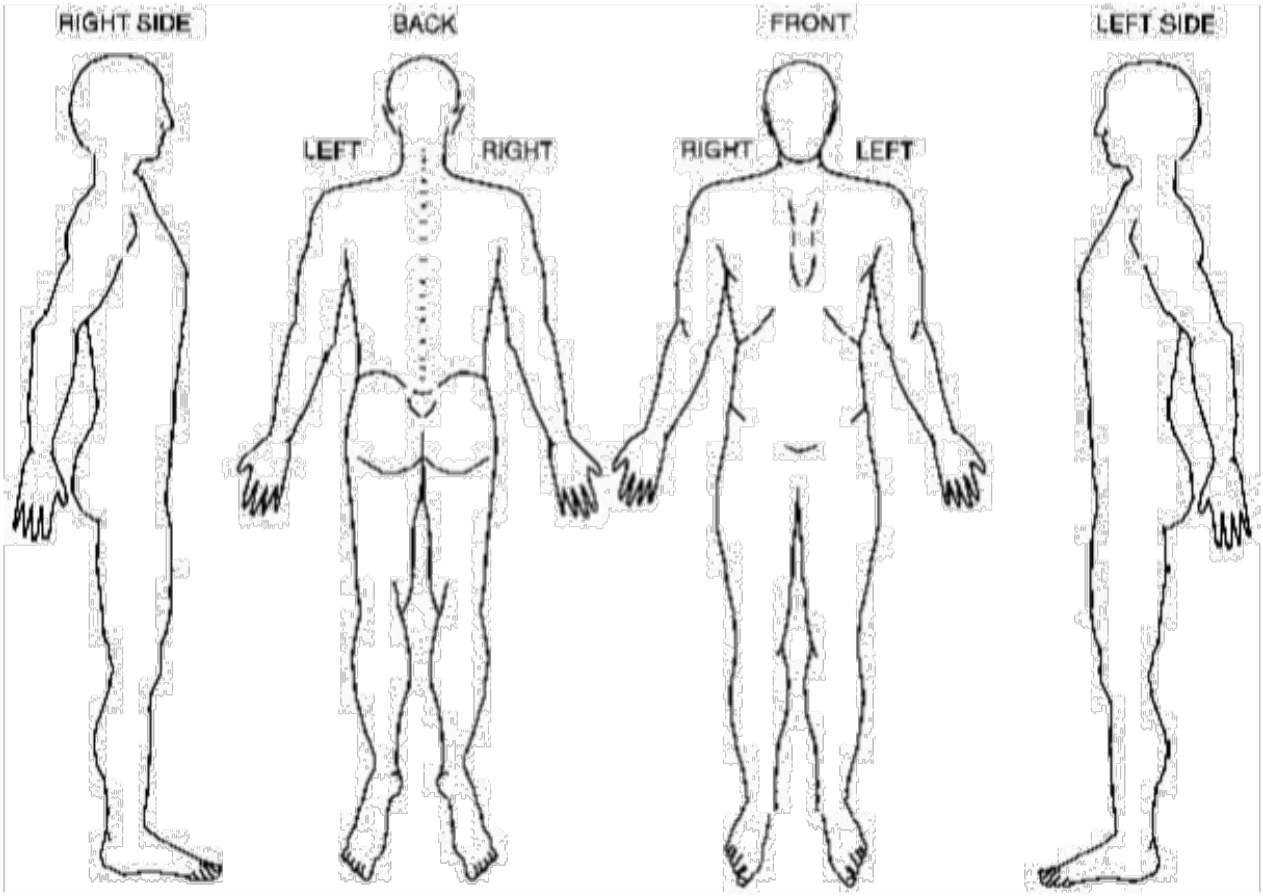
Alcohol: ☐ NO ☐ YES

Tobacco: ☐ NO ☐ YES

Narcotics: ☐ NO ☐ YES

Location of Symptoms or Pain

On the diagram below, please indicate the location of where your pain or symptoms occur. If the pain begins in one spot and travels to another, then draw a line to where it ends. If it involves a whole area, then shade in the affected area(s).



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Patient Name: _____ Date of Birth: _____

Health History

Have you had any surgeries or ever been hospitalized? Please indicate when/for how long.

_____

_____

_____

_____

_____

_____

Have you been diagnosed with any medical conditions? Please indicate whether or not you are currently being treated for each diagnosis.

_____

_____

_____

_____

_____

_____

CACTUS NEEDLE

Patient Name: _____ Date of Birth: _____

Chief Concerns and Other Pertinent Health Information

What would you like to me to treat/focus on?

_____

_____

_____

_____

_____

_____

Is there anything else that I should know? *(about you, your health history, etc.)*

_____

_____

_____

_____

_____

_____

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Patient Name: _____ Date of Birth: _____

Medications, Herbs, and Supplements List

Please list any medications, herbs, and/or supplements that you take:

Name of Drug/Herb/Supplement	Dosage	Frequency	Reason for taking