E. Bennett, AP
Acupuncture & Herbal Medicine

CONFIDENTIAL

E. Bennett, AP Acupuncture & Herbal Medicine, LLC 2733 Gulf Breeze Parkway Gulf Breeze, FL 32563 Phone: (850) 781-9888

Welcome to the Clinic

Please take a moment to provide some information about yourself and your health concerns. We will go into more depth about your condition(s) during our session. This information is considered privileged physician/patient communication and will be held in confidence.

Patient Information

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____ **Preferred: HM WK CL**

Email: _____

May I contact you for appt. reminders? **Yes / No** Preferred method of reminder: **Phone / email**

Would you like to receive emails regarding specials and clinic-related events? **Yes / No**

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Marital/Relationship Status: _____ Occupation: _____

Number of Children: _____ Ages of Children: _____ Number who live with you: _____

Primary Care Physician: _____ Last Visit: _____

How did you hear about this clinic? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Current Health

Reason for your visit here today: _____

When did this condition begin? _____

Rate the severity of the main complaint (1=mild, 10=severe) **1 2 3 4 5 6 7 8 9 10**

What helps the condition? _____

What makes the condition worse? _____

Are you being treated for this condition by anyone else? **Yes / No**

If yes, who? _____ Phone: _____

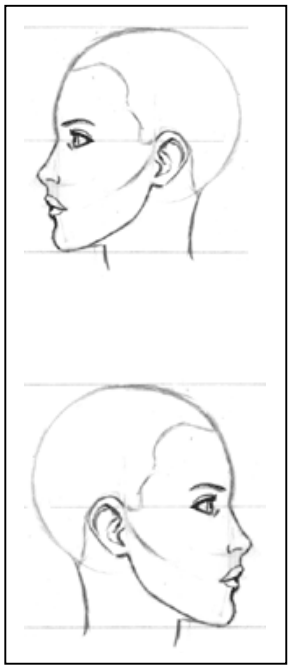
How are these treatments helping you? _____

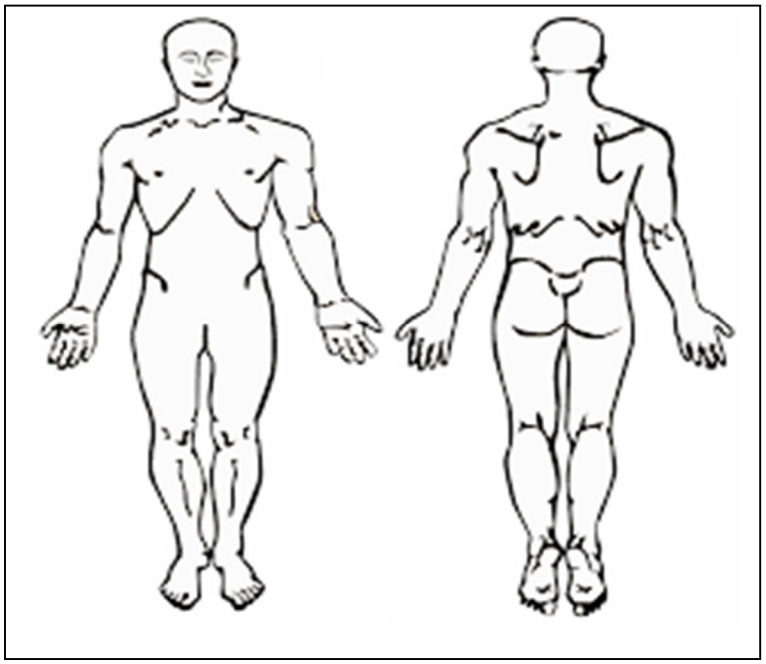
Has this condition been diagnosed by an MD? **Yes / No** If yes, diagnosis: _____

Known or suspected allergies: _____

Most recent blood pressure reading: _____

Please mark painful or distressed areas on the charts below (as it applies):





Symbol	Reaction
PAIN	
X	Mild
XX	Moderate
XXX	strong
SWELLING	
^	Slight
^^	Moderate
^^^	Severe
PULSING	
O	Mild
OO	Moderate
OOO	Severe
WEAKNESS / TEMP	
-	Weak
+	Hot
SKIN CONDITION	
*	Skin Issue

Lifestyle

EXERCISE	□ Sedendary (No exercise)
	□ Mild exercise (i.e. climb stairs, walk 3 blocks, golf)
	□ Occasional vigorous exercise (workout/recreation, less than 4 times per week for 30 minutes)
	□ Regular vigorous exercise (workout/recreation 4 times per week or more for 30 minutes)
DIET	Are you dieting? □Yes □No
	If yes, are you on a physician prescribed medical diet? □Yes □No
	Number of meals you eat in an average day?
	Describe daily diet:
CAFFEINE TOBACCO ALCOHOL / DRUGS	Indicate number of cups/cans per day: □Coffee □Tea □Soda
	Tobacco: _____packs per day Type? Number of years?
	Do you drink alcohol? □Yes □No Drinks per week:
	Do you use recreational drugs? □Yes □No What type?
	Frequency of use:
SLEEP HABITS	Number of hours per night (average):
	Do you wake feeling rested (explain)?
	Do you have difficulty falling asleep? □Yes □No
	Do you have difficulty staying asleep? □Yes □No
	Do you dream (explain)?

Health History

Please check all that apply:

GENERAL	☐ Poor Appetite	☐ Weight Gain	☐ Night Sweats
	☐ Insomnia	☐ Weight Loss	☐ Fever
	☐ Disturbed Sleep	☐ Sweating Easily	☐ Chills
	☐ Localized Weakness	☐ Bleeding / Bruising	☐ Sudden Energy Drop
	☐ Cravings	☐ Tremors	☐ Poor Balance
	☐ Strong Thirst		
HAIR, SKIN, NAILS	☐ Rashes	☐ Eczema	☐ Recent Moles
	☐ Ulcerations	☐ Acne	☐ Changes in Hair Texture
	☐ Hives	☐ Dandruff	☐ Hair Loss
	☐ Itching	☐ Sunburn	☐ Weak Nails
HEAD, EYES, EARS, NOSE, THROAT	☐ Dizziness	☐ Color Blindness	☐ Recurrent Sore Throats
	☐ Concussions	☐ Cataracts	☐ Nose Bleeds
	☐ Migraines	☐ Blurry Vision	☐ Grinding Teeth
	☐ Glasses	☐ Earaches	☐ Sores on Lips or Tongue
	☐ Spots in Front of Eyes	☐ Ringing in the Ears	☐ Facial Pain
	☐ Eye Pain	☐ Poor Hearing	☐ Teeth Problems
	☐ Poor Vision	☐ Eye Strain	☐ Headaches
	☐ Night Blindness	☐ Sinus Problems	☐ Jaw Clicks
	☐ Photophobia	☐ TMJ	☐ Gum / Teeth Problems
CARDIOVASCULAR	☐ Dizziness	☐ Tightening in the Chest	☐ Swelling of Feet
	☐ Low Blood Pressure	☐ Fainting	☐ Blood Clots
	☐ High Blood Pressure	☐ Cold Hands and/or Feet	☐ Difficulty Breathing
	☐ Chest Pain	☐ Swelling of Hands	☐ Phlebitis
	☐ Irregular Heartbeat	☐ Palpitations	☐ Stroke
RESPIRATORY	☐ Cough	☐ Bronchitis	☐ Frequent Colds or Flu
	☐ Asthma	☐ Shortness of Breath	☐ Excessive Phlegm
GASTROINTESTINAL	☐ Nausea	☐ Belching	☐ Rectal Pain
	☐ Vomiting	☐ Black Stools	☐ Hemorrhoids
	☐ Diarrhea	☐ Blood in Stools	☐ Abdominal Pain / Cramping
	☐ Constipation	☐ Indigestion	☐ Chronic Laxative Use
	☐ Gas / Bloating	☐ Bad Breath	☐ Crohn's
	☐ Parasites	☐ Diverticulosis / Diverticulitis	☐ Colitis
	☐ Ulcer	☐ GERD	☐ IBS
GENITOURINARY	☐ Painful Urination	☐ Incontinence	☐ Sores on Genitals
	☐ Urinary Infections	☐ Decrease in Flow	☐ Impotence / Frigidity
	☐ Blood in Urine	☐ Kidney Stones	☐ Low to No Sex Drive
MUSCULOSKELETAL	☐ Neck Pain	☐ Back Pain	☐ Hand / Wrist Pain
	☐ Muscle Pain	☐ Muscle Weakness	☐ Shoulder Pain
	☐ Knee Pain	☐ Numbness / Tingling	☐ Hip Pain
	☐ Sciatica	☐ Vericose Veins	☐ Foot / Ankle Pain
	☐ Arthritis		
NEUROPSYCHOLOGICAL	☐ Seizures	☐ Poor Memory	☐ Anxiety
	☐ Dizziness	☐ Depression	☐ Bad Temper
	☐ Loss of Balance	☐ Concussion	☐ Frequent Mood Swings
OTHER ILLNESS	☐ HIV Positive	☐ Rheumatic Fever	☐ Eating Disorder
	☐ AIDS	☐ Hypoglycemia	☐ Jaundice
	☐ Epstein-Barr	☐ Type I Diabetes	☐ Hepatitis
	☐ Mononucleosis	☐ Type II Diabetes	☐ Autoimmune Disorder
	☐ Contagious Illness, Please Specify _____		

Mental Health

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed or otherwise?	☐ Yes	☐ No
Do you have problems with eating or with your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever been to a counselor / therapist?	☐ Yes	☐ No
Do you have a history of trauma / abuse?	☐ Yes	☐ No

Women's Health

Age at onset of menstruation:	Date of last menstruation:	
Period occurs every _____ days, or other (please explain):		
Number of pregnancies: _____ Number of live births: _____		
Heavy periods, spotting, pain, or discharge?	☐ Yes	☐ No
Are you pregnant or breastfeeding?	☐ Yes	☐ No
D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Hot flashes or night sweats?	☐ Yes	☐ No
Tension, pain, bloating, irritability, or other symptoms at or around time of menstruation?	☐ Yes	☐ No
Breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No

Men's Health

Recent kidney, bladder, or prostate infection?	☐ Yes	☐ No
Problems emptying bladder completely?	☐ Yes	☐ No
Difficulty with erection or ejaculation?	☐ Yes	☐ No
Testicle Pain or Swelling?	☐ Yes	☐ No
BPH or chronic prostatitis?	☐ Yes	☐ No
Burning or discharge from penis?	☐ Yes	☐ No

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS (OR PROVIDE LIST TO PRACTITIONER)