

Spirit Path Acupuncture LLC

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Patient Information and Health History

Name _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Today's Date _____ Birth Date _____

Marital Status _____ Name of Partner _____

Children? _____ Names _____

Length of current relationship _____ Place of Birth _____

Education _____ Occupation _____

What brings you to acupuncture? _____

Date of Last Physical Exam _____ By Whom? _____

How did you hear about us? _____

Please List All Medications You Are Taking:

_____ Amount _____ Prescribed? _____

_____ Amount _____ Prescribed? _____

_____ Amount _____ Prescribed? _____

_____ Amount _____ Prescribed? _____

_____ Amount _____ Prescribed? _____

Health History: Have you ever been diagnosed with any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> Coronary Disorder or Heart Attack |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Lung or Respiratory Disorder | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> Liver Disease or Hepatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Back Pain or Sciatica |
| <input type="checkbox"/> Urinary or Bladder Infection | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Chest Pain or Angina Pain | <input type="checkbox"/> Kidney Disorder or Kidney Stones |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Gall Bladder Disorder or Gall Stones | <input type="checkbox"/> Cancer or Tumors |
| <input type="checkbox"/> Pelvic or Genital Pain | <input type="checkbox"/> Spleen or Lymphatic Disorder |
| <input type="checkbox"/> HIV+ or AIDS | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Gastric or Peptic Ulcer | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Irritable Bowel Syndrome or Colitis |
| <input type="checkbox"/> Polio or Mononucleosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Allergies or Hayfever |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Asthma or Bronchitis | <input type="checkbox"/> Bone Fracture/Joint Sprain |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Muscle Spasm or Tremor | <input type="checkbox"/> Dysmenorrhea (Painful Menstruation) |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Pre-Menstrual Syndrome | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Tennis Elbow | <input type="checkbox"/> Prostate or Vaginal Disorder |
| <input type="checkbox"/> Obsessive-Compulsive Disorder | <input type="checkbox"/> Frozen Shoulder |
| <input type="checkbox"/> Skin Disorder, Eczema, Psoriasis | <input type="checkbox"/> Panic Attacks or Phobias |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Major Depression | <input type="checkbox"/> Shingles (Herpes Zoster) |
| <input type="checkbox"/> Deafness or Tinnitus | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Other: Please Specify | |

Accidents: Have you ever been injured in any of the following types of accidents?

- | | | |
|--|--|---|
| <input type="checkbox"/> Automobile Accident | <input type="checkbox"/> Work Related Accident | <input type="checkbox"/> Accident at Home |
| <input type="checkbox"/> Athletic Injury | <input type="checkbox"/> Surgical Complication | <input type="checkbox"/> Other Accident |
| <input type="checkbox"/> Other: Please Specify | | |
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Current Conditions: In the past year, have you noticeably experienced any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> Large Weight Gain or Weight Loss |
| <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Pain in Arms, Wrist, Hands |
| <input type="checkbox"/> Overeating or Binge Eating | <input type="checkbox"/> Colds, Flu or Chills |
| <input type="checkbox"/> Cold Hands or Cold Feet | <input type="checkbox"/> Undereating or Poor Appetite |
| <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Swollen Ankles or Feet |
| <input type="checkbox"/> Craving for Sweets or Chocolate | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Stiff, Aching Joints | <input type="checkbox"/> Craving for Drugs or Alcohol |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Neck or Shoulder Tension |
| <input type="checkbox"/> Dissatisfaction with Job | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Grinding Your Teeth | <input type="checkbox"/> Bored or Uninterested in Things |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Loneliness or Lack of Affection | <input type="checkbox"/> Lethargy, Fatigue |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Sex Life Not Satisfying |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Hyperventilation |
| <input type="checkbox"/> Thoughts of Killing Yourself | <input type="checkbox"/> Disturbing Dreams |
| <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Worried About Finances |
| <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Other: Please Specify |
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Substances or Medications: In the past several months, did you regularly take any of these?

- | | |
|--|---|
| <input type="checkbox"/> Cigarettes or Cigars | <input type="checkbox"/> Aspirin or Tylenol |
| <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Several Cups of Coffee/Day |
| <input type="checkbox"/> Prescribed Pain Reliever Medication | <input type="checkbox"/> Anti-Anxiety Pills |
| <input type="checkbox"/> Glass of Beer or Wine | <input type="checkbox"/> Recreational Drugs/Marijuana |
| <input type="checkbox"/> Anti-Depressant Pills | <input type="checkbox"/> Liquor or Mixed Drinks |
| <input type="checkbox"/> Several Cans of Soda/Day | <input type="checkbox"/> Blood Pressure Pills |
| <input type="checkbox"/> Other: Please Specify | |
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Patient or Parent/Guardian Signature