

Relax-u-puncture
Acupuncture and Craniosacral Therapy
New Patient Comprehensive Health Assessment

In order to provide you with a comprehensive health assessment and treatment plan, please respond to the following questions as carefully and accurately as possible. All your answers are confidential.

Date: _____ Full Name: _____ Nickname: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-Mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Relationship/ Marital Status: _____

Occupation: _____ Height: _____ Weight: _____

In Emergency Notify: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

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

Other Care Providers (physicians, massage therapists, chiropractors, psychotherapists)

1. _____

2. _____

3. _____

4. _____

Do I have your permission to confer with your other health care practitioners? YES _____ NO _____

Have you been treated with acupuncture or craniosacral therapy before? YES _____ NO _____

How did you hear about Relax-u-puncture? *friend/associate (please give us their name), Newspaper article, Internet site, Doctor referral?* _____

CANCELLATION POLICY: Please allow at least 24 HOURS notice of cancellation for your reserved appointment. You will be charged in full for late cancellations or missed appointments. _____ patient initials and date acknowledging policy.

Patient Information

Confidential Patient Health History

What is your major complaint? (Please describe in your own words any symptoms you are experiencing)

How long have you had this condition? _____ Have you ever had this or a similar condition in the past? _____

List previous diagnoses and treatments you have received for your present complaint.

What do you believe is wrong with you?

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

What other kinds of treatments have you tried?

List any medications taken within the last two months (vitamins, herbs, drugs, etc.), names, dosages, and reason for taking.

How often do you take Aspirin, Ibuprofen, or Antacids?

Do you have any allergies (chemical, environmental, food, drugs, etc.)

Do you have a regular exercise program? Yes No If yes, please describe (type of exercise, days per week, duration of workout)

Please describe your average daily diet:

Meals per day	
Snacks per day:	

How many times/week do you eat meat (beef, pork, poultry, fish)?

How many times / week do you have dairy products?

How much sugar and white flour products do you consume per day?

Do you smoke? Yes No If yes, how many packs/day, for how long?

Are you exposed to second hand smoke? If yes how much for how long?

How many caffeinated drinks do you have /day? (soda, tea, coffee?)

How many glasses of water do you drink per day?

Do you drink alcohol? If yes, how much? How often?

Please describe any use of drugs for non-medical purposes: (marijuana, cocaine, etc.)

Significant Trauma, Physical or Emotional: (List any auto, sporting accidents, falls, abuse history etc.)

Hospitalizations and Surgeries (please include date of procedure)

Occupational stress (chemical, psychological, physical, etc.)

PERSONAL Medical History:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Head or neck trauma | <input type="checkbox"/> Infertility | <input type="checkbox"/> HIV/AIDS |

FAMILY Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes ____ | <input type="checkbox"/> Seizures ____ | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer/ what kind ____ | <input type="checkbox"/> Asthma ____ |
| <input type="checkbox"/> Other _____ | | | |

Comprehensive Health Assessment:

DIRECTIONS

- Please X any conditions/ symptoms that you are experiencing NOW.
- Please check any conditions you have had in the past but DO NOT HAVE any longer.

Section 1: Metabolism:

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Hot Tendency | <input type="checkbox"/> Tired after eating |
| <input type="checkbox"/> Heavy Appetite | <input type="checkbox"/> Fevers | <input type="checkbox"/> Needs coffee in am |
| <input type="checkbox"/> Cold tendency | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily/strong odor |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Weight loss/ underweight | |
| <input type="checkbox"/> Restless/ Hyperactive | <input type="checkbox"/> Weight gain/ overweight | <input type="checkbox"/> Peculiar tastes in mouth |
| <input type="checkbox"/> Fatigued/ Lethargic | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) |

Section 2: Skin and Hair

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Easily bruise | <input type="checkbox"/> Brown spots | <input type="checkbox"/> red spots or bumps |

Section 3: Head, Eyes, Ears, Nose and Throat

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Glasses/ contacts | <input type="checkbox"/> Poor Night vision |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Glasses/ Contacts | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Eye pain/pressure | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Sneezing | <input type="checkbox"/> TMJ, Jaw clicks/locks | <input type="checkbox"/> Poor sense of Taste |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Dental Problems |

Section 4: Cardiovascular

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> High Cholesterol (>200) | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Blood clots | <input type="checkbox"/> rapid pulse (>82) |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> High Trig(>135) | <input type="checkbox"/> rapid pulse (>82) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold extremities |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Heaviness in legs | <input type="checkbox"/> History of Stroke |
| <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Pain in legs/walking | <input type="checkbox"/> Swelling in ankles | <input type="checkbox"/> History of Heart Attack |

Section 5: Lung/ Respiratory

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Production of phlegm... what color? _____ | | |

Section 6: Immune Function

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Swollen lymph glands | <input type="checkbox"/> Frequent antibiotic use | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Flus | <input type="checkbox"/> Slow wound healing | <input type="checkbox"/> Sore Throats | <input type="checkbox"/> History of Shingles |
| <input type="checkbox"/> Slow recovery | <input type="checkbox"/> Fevers | <input type="checkbox"/> Childhood vaccines | <input type="checkbox"/> Scars |

Section 7: Gastrointestinal Tract

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood/ mucous in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain/ itching | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Poor/ Loss of Appetite | <input type="checkbox"/> Acid reflux/GERD/ | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hard stools |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | <input type="checkbox"/> Pebble shape stools |
| <input type="checkbox"/> History of Gallstones | <input type="checkbox"/> Heartburn | <input type="checkbox"/> History of Ulcers | <input type="checkbox"/> Thin stools |

Section 8: Urinary Tract

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow |
| <input type="checkbox"/> Dripping after urine | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Hard to start urine | <input type="checkbox"/> Flank/ Kidney Pain | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> strong odor |
| <input type="checkbox"/> History of Kidney Stones | <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Night urination What time? _____ How often? _____ | |

Section 9: Men Only

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Swollen genitals | <input type="checkbox"/> History of STD* | <input type="checkbox"/> Premature Ejaculation |
| <input type="checkbox"/> Pain in genital area | <input type="checkbox"/> Rash/ sores in genital area | <input type="checkbox"/> History of Prostatitis | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Inguinal Hernia | <input type="checkbox"/> Discharge from penis | <input type="checkbox"/> Prostate enlarged | <input type="checkbox"/> Nocturnal Emission |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Excessive Libido | *Sexually Transmitted Disease | |

Section 10: Women Only

Premenstrual Symptoms:

- | | | |
|--|---|---|
| <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Bloating/ Cramping | <input type="checkbox"/> Low back aches |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Water retention | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Cravings |

Menstrual Symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Heavy menses | <input type="checkbox"/> Missed periods |
| <input type="checkbox"/> Cycle < 28 days | <input type="checkbox"/> Long menses (> 5 days) | <input type="checkbox"/> Abnormal/ break through bleeding |
| <input type="checkbox"/> Cycle > 30 days | <input type="checkbox"/> Short menses (< 5 days) | <input type="checkbox"/> Light flow menses |
| <input type="checkbox"/> Heavy Blood Flow | <input type="checkbox"/> Clotting | <input type="checkbox"/> Dark color blood |
| <input type="checkbox"/> Age of first menses _____ | <input type="checkbox"/> Date of Last menses _____ | <input type="checkbox"/> Date of last PAP/ Pelvic Exam _____ |
| <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of pregnancies _____ | <input type="checkbox"/> Number of live births _____ |
| <input type="checkbox"/> Number of etopic preg _____ | <input type="checkbox"/> Number of abortions | <input type="checkbox"/> Number of miscarriages _____ |

Are you pregnant now? _____ Is there a chance that you may be pregnant now? _____
 Do you practice birth control? _____ What type? _____ For How Long? _____
 Have you experienced Menopause yet? _____ If yes, at what age did it begin?
 Have you ever used estrogen drugs? _____ If yes, for how many years? _____

Other Female Problems:

- | | | |
|--|--|---|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Breast Lumps |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Breast Implants |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Hot sensation on palms of hands/ feet |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> History of Pelvic Inflammatory Disease |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> History of Sexually Transmitted Disease | |
| <input type="checkbox"/> Family History of breast cancer? _____ What was their relationship to you? _____ | | |
| <input type="checkbox"/> Abnormal PAPs (if yes, circle diagnosis- Inflammation, Atypia, Dysplasia, HPV, Other) | | |

Section 11: Musculoskeletal

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Joint pain/ stiffness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Disc Herniation | <input type="checkbox"/> Spinal curvature |
| <input type="checkbox"/> Back pain Low ___ Middle ___ Upper ___ | | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> weakness in lower body (back, knee, hip, ankle, foot) | | | |
| <input type="checkbox"/> Auto accident | | | |

Section 12: Neurological

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Light headedness |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Trembling | <input type="checkbox"/> Pain worse with Stress | <input type="checkbox"/> Fainting |

Section 13 Psychological/ Emotional

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Moody | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Indecisive | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Lonely | <input type="checkbox"/> Impatient | <input type="checkbox"/> Seasonal Affect Disorder | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Nervous with strangers | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Manic Depression | <input type="checkbox"/> Cries easily/ often |
| <input type="checkbox"/> Jittery/ Shaky | <input type="checkbox"/> Angry | <input type="checkbox"/> Grief | <input type="checkbox"/> worried |
| <input type="checkbox"/> Mental dullness | <input type="checkbox"/> Worries A lot | <input type="checkbox"/> Annoyed by little things | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Hopeless Outlook | <input type="checkbox"/> Frightening dreams/thoughts | <input type="checkbox"/> Shy | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Difficulty relaxing | <input type="checkbox"/> Easily loses temper | <input type="checkbox"/> Family/ Home Problems | |

Have you ever been treated for emotional problems? Yes No
 Have you ever considered or attempted suicide? Yes No
 Have you ever been treated for substance abuse? Yes No
 Have you recently suffered a loss of someone who is close to you? _____
 Are you a caretaker for someone who is ill or disabled? _____

Relax-u-puncture
Acupuncture and Craniosacral Therapy

Subjective Stress Assessment

Name: _____

Date: _____

DIRECTIONS: Circle the number that corresponds most closely to how you rate yourself on the scale below. For example, if you are almost always relaxed circle **1**. if you are almost always tense, circle **10**; a rating of **5** would be half-and-half. Usually the answer that comes to your mind first is the most accurate.

1. Relaxed	1	2	3	4	5	6	7	8	9	10	Tense
2. Calm	1	2	3	4	5	6	7	8	9	10	Anxious
3. Worry free	1	2	3	4	5	6	7	8	9	10	Worry excessively
4. Happy	1	2	3	4	5	6	7	8	9	10	Depressed
5. High energy	1	2	3	4	5	6	7	8	9	10	Low energy
6. Sleep good	1	2	3	4	5	6	7	8	9	10	Sleep poor
7. Bed comfortable	1	2	3	4	5	6	7	8	9	10	Uncomfortable
8. Unhurried	1	2	3	4	5	6	7	8	9	10	Hurried/ Pressured
9. Care free	1	2	3	4	5	6	7	8	9	10	Overcommitted
10. Daily relaxation	1	2	3	4	5	6	7	8	9	10	No daily relaxation
11. Time for hobbies and recreation	1	2	3	4	5	6	7	8	9	10	No time for hobbies/recreation
12. Time for contemplation	1	2	3	4	5	6	7	8	9	10	No time for contemplation/ reflection
13. Enjoy occupation	1	2	3	4	5	6	7	8	9	10	Detest job
14. Satisfying life	1	2	3	4	5	6	7	8	9	10	Frustrated
15. Expectations fulfilled	1	2	3	4	5	6	7	8	9	10	Not fulfilled
16. Achieving personal goals	1	2	3	4	5	6	7	8	9	10	Not achieving goals
17. Loved	1	2	3	4	5	6	7	8	9	10	Not loved
18. Loving	1	2	3	4	5	6	7	8	9	10	Angry/ resentful
19. Quiet environment	1	2	3	4	5	6	7	8	9	10	Noisey environment
20. Ordered surroundings	1	2	3	4	5	6	7	8	9	10	Chaotic surroundings

