Sarah Senter, L.Ac., ACN
License # TX 00885

Personal Information & General Health Intake

Important: The information in this form will help your practitioner (Sarah Senter, L.Ac) give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing or underlying role in the diagnosis and treatment of your problem.

****All of the information provided is strictly confidential****

General Patient Information

Name:_____ Age:_____

DOB : _____/_____/_____

Gender: Male / Female / Prefer to Self-Describe: _____

Marital Status: Single / Married / Separated / Divorced / Widowed

Weight: _____lbs Height: ___'____" # of children, if any: _____

Occupation: _____

Address: _____

City:_____ State:_____ Zip:_____

Home phone:_____ Cell:_____ Work:_____

Email address: _____

How did you hear about my practice? _____
or
Who can I thank for your referral? _____

Name of Guardian (if under 18):_____

Emergency Contact Name:_____Relationship: _____

Emergency contact phone number:_____

Have you ever received acupuncture therapy before today? Yes / No

If so, for what type of problem and when? _____
_____

Please list any prescription medications you have taken in the last three months:

Medication	Reason	Dosage

Please check all that apply to your diet:

___Coffee, # cups/day?___
___Tea, # cups/day?___
___Sodas, how many/day?___
___Artificial Sweeteners/Diet drinks
___Alcohol, # drinks/day?_____
___Fast Food, how often?_____

I am a ___Vegetarian ___Vegan

Are you a smoker? ____ Yes ____ No

Please list any nutrition supplements or herbal medicines you have taken in the last three months:

Supplement	Reason	Dosage

<u>Patient Profile:</u> Please check all of the following that *currently* apply to you:

Skin and Hair:

- ❑ Loss of Hair
- ❑ Dry Skin
- ❑ Dry hair/dandruff
- ❑ Eczema
- ❑ Psoriasis
- ❑ Brittle Nails
- ❑ Hives
- ❑ Acne/Rosacea
- ❑ Skin ulcerations

Musculoskeletal:

- ❑ Muscle weakness
- ❑ Tremors/spasms
- ❑ Numbness or tingling
- ❑ Back pain
- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Hip/buttock pain
- ❑ Knee pain
- ❑ Ankle pain
- ❑ Wrist pain
- ❑ Joint pain/Arthritis
- ❑ Hernia

Head, Eyes, Ears, Nose and Throat:

- ❑ Migraines
- ❑ Headaches
- ❑ Blurry/Poor vision
- ❑ Sinus problems
- ❑ Sore throat
- ❑ Floaters
- ❑ Dizziness
- ❑ Difficulty swallowing
- ❑ Ear ache/pain
- ❑ Ear ringing
- ❑ Dry eyes
- ❑ Red eyes
- ❑ Watery eyes
- ❑ Hearing loss
- ❑ Teeth/gum problems

Cardiovascular:

- ❑ Chest pain
- ❑ High blood pressure
- ❑ History of blood clots
- ❑ Fainting
- ❑ Low blood pressure
- ❑ Irregular Heartbeat
- ❑ Heart Palpitations
- ❑ Varicose veins

Respiratory:

- ❑ Asthma/Allergies
- ❑ Cough
- ❑ Frequent colds/flus
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Shallow breathing
- ❑ Phlegm production

Gastrointestinal:

- ❑ Vomiting
- ❑ Indigestion
- ❑ Acid reflux
- ❑ Bloating
- ❑ Belching
- ❑ Nausea
- ❑ Bad breath
- ❑ Frequent thirst
- ❑ Lack of thirst
- ❑ Flatulence/Gas
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Loose stools/Diarrhea
- ❑ Ulcers
- ❑ Hemorrhoids

Bowel movement frequency (per day or week): _____

Genito-urinary:

- ❑ Frequent nighttime urination
- ❑ Frequent UTIs
- ❑ Incontinence
- ❑ Genital pain
- ❑ Genital itching
- ❑ Kidney stones
- ❑ Impotence
- ❑ Hesitancy in flow of urination
- ❑ Excessive libido
- ❑ Low libido

Color of urination: Clear / Cloudy / Pale yellow / Dark yellow / Reddish color

Neuro-psychological:

- ❑ Anxiety
- ❑ Irritability
- ❑ Worries easily
- ❑ Fearful
- ❑ Restlessness
- ❑ Panic attacks
- ❑ Mental fatigue
- ❑ Depression
- ❑ Stress
- ❑ Suicidal feelings
- ❑ Short temper
- ❑ Extreme shyness
- ❑ Tendency to be obsessive in work or relationships

Temperature:

- ❑ Tend to feel cold
- ❑ Tend to feel hot
- ❑ Cold hands and feet
- ❑ Hot flashes
- ❑ Night sweating
- ❑ Sweat easily/spontaneously
- ❑ Sweaty palms/soles
- ❑ Aversion to Hot / Cold

Women's Health (Females only):

- ❑ Fertility problems
- ❑ Endometriosis
- ❑ Vaginal dryness
- ❑ Vaginal pain, redness, or swelling
- ❑ Frequent infections: Pelvic / Vaginal / UTI
- ❑ Vaginal discharge
- ❑ Ovarian cysts
- ❑ Fibroids
- ❑ Irregular periods
- ❑ Menopausal Hot flash or Night sweats
- ❑ Peri-menopausal

Do you experience any of the following symptoms before, during, or after your period? Please check all that apply:

- ❑ Irritability
- ❑ Headaches or Migraines
- ❑ Cramping
- ❑ Loose stools
- ❑ Breast tenderness
- ❑ Bloating
- ❑ Back pain
- ❑ Fatigue

Other?_____

Is there a possibility that you are pregnant? Yes / No

Post-Menopausal:
Age periods ceased:_____ Hysterectomy? Age and reason_____

Please answer Yes or No to the following statements:

I have been evaluated by a physician or a dentist for the condition being treated within twelve months prior to having acupuncture performed. YES / NO

I have received a referral from a Chiropractor within the last 30 days for Acupuncture. YES / NO

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. If after 60 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

I have read, or have had read to me, and understand all of the above information and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____
Patient Signature or Signature of Patient's Guardian Date signed

_____ _____
Printed name of Patient's Guardian (if applicable) Relationship or Authority

Thank you!

SARAH SENTER, LAc