Alivia Acupuncture Clinic, LLC

Karla Sourasky Olmos, L. Ac

Patient Information

Name _____ Age _____ Date of birth _____

Address _____

City _____ State _____ Zip _____

Email _____

Home Phone _____ Work phone _____ Cell Phone _____

Marital Status ___ Single ___Married ___Divorced ___Separated ___Widow

Occupation _____ Employer _____

Emergency contact _____ Relationship _____

Phone number _____

Primary Care provider _____ Phone _____

How do you want to be contacted? ___ Home phone ___Work phone __Cell phone ____ Email

How did you hear about us? _____

Medical Complaint

Reason for your visit:

_____

_____

_____

For how long have you had this condition? _____

What makes it better? _____

What makes it worse?_____

Have you being treated for this condition by another health care practitioner? _____

Have this treatment helped? _____

Do you have a medical diagnosis? _____

Have you had acupuncture before? _____

Do you currently have an infectious disease ___Yes ___No ___Possibly

Health Information

Hospitalizations/Surgeries

_____
_____
_____

Allergies (Medications, foods, environmental)

_____
_____
_____

Prescription medications, dosage and frequency

_____
_____
_____
_____
_____
_____

Over the counter medications, dosage, frequency

_____
_____
_____
_____
_____
_____

Medical History

Head	Ears, nose, throat	Eyes	Neurological
☐ Headaches ☐ Migraines ☐ Bell's Palsy ☐ Facial pain ☐ Hair loss ☐ Jaw pain/TMJ	☐ Change in hearing ☐ Ear ringing ☐ Earache ☐ Ear infections ☐ Allergies ☐ Nose congestion ☐ Runny nose ☐ Frequent colds ☐ Nose bleeds ☐ Sinus problems ☐ Difficulty swallowing ☐ Hoarseness ☐ Frequent sore throats	☐ Impaired vision ☐ Eye pain ☐ Blurred vision ☐ Tearing ☐ Dryness ☐ Cataracts ☐ Glaucoma ☐ Redness ☐ Glasses/contacts	☐ Dizziness ☐ Vertigo ☐ Fainting ☐ Loss of balance ☐ Seizure ☐ Poor memory ☐ Insomnia ☐ Numbness/tingling ☐ Paralysis ☐ Tremors ☐ Night headaches
Respiratory	**Cardiovascular**	**Gastrointestinal**	**Urinary/Kidney**
☐ Frequent colds ☐ Asthma ☐ Difficulty breathing ☐ Emphysema ☐ Cough ☐ Tuberculosis	☐ High blood pressure ☐ Low blood pressure ☐ Heart disease ☐ Chest pain ☐ Palpitations ☐ Irregular heart beat ☐ Pacemaker ☐ Varicose veins ☐ Edema ☐ Stroke ☐ Taking Coumadin/ Warfarin ☐ Taking Aspirin	☐ Bad breath ☐ Changes in appetite ☐ Belching ☐ Nausea/vomiting ☐ Heartburn ☐ Gastro esophageal reflux (GERD) ☐ Indigestion ☐ Bloating ☐ Gas ☐ Constipation ☐ Loose stools ☐ Diarrhea ☐ Irritable Bowel syndrome (IBS) ☐ Crohn's Disease ☐ Ulcerative colitis ☐ Hemorrhoids ☐ Gall Bladder	☐ Kidney Disease ☐ Kidney Stones ☐ Bladder/Kidney infections ☐ Painful urination ☐ Frequent urination ☐ Recurrent UTI ☐ Cloudy urine ☐ Blood in urine ☐ Frequent urination ☐ Incontinence ☐ Urgency ☐ Nighttime urination

		disease ☐ Liver disease	

Endocrine	Muscular-skeletal	Emotional	Skin
☐ Hyperthyroid ☐ Hypothyroid ☐ Diabetes ☐ Hypoglycemia ☐ Excessive sweating ☐ Night sweats ☐ Feeling hot/cold	☐ Joint pain ☐ Joint stiffness ☐ Arthritis ☐ Muscle cramps ☐ Back pain ☐ Carpal tunnel ☐ Osteoporosis ☐ Fibromyalgia	☐ Depression ☐ Anxiety ☐ Anger ☐ Fear ☐ Grief/sadness ☐ Worry/overthinking ☐ ADHD ☐ Panic Attacks ☐ Aggression	☐ Acne ☐ Dry skin ☐ Slow wound healing ☐ Easy bruising ☐ Rashes ☐ Psoriasis ☐ Itching
Sleep	**Other**		
☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Grinding teeth ☐ Nightmares ☐ Sleep apnea	☐ Fatigue ☐ Allergies ☐ Weight loss ☐ Weight gain ☐ Anemia		

For Men

___ Impotence ___ Vasectomy Date: _____

___ Testicular pain/redness/swelling ___ Prostate problems ___ Seminal emissions

___ Low libido ___ Excess libido ___ Painful intercourse

For Women

Are you pregnant? ___ Yes ___ No ___Trying ___ Maybe

Method of birth control: _____

Age at first period _____ Start date of last menses _____ Age at menopause _____

Typical length of menses (days) _____ Length of cycle (from 1st day of menses to the 1st day of next month menses) _____

Number of pregnancies _____ Births _____ Abortions ____ Miscarriages ____

Hysterectomy ___yes ___ No Date _____

Check if apply:

___ Painful periods ___ Irregular cycles ___ Scanty flow

___ Heavy flow ___ Clotting ___ Inter-cycle bleeding

___ Endometriosis ___ PMS

___ Fibroids ___ Low libido ___ Excess libido

___ Painful intercourse ___ Infertility ___ Vaginal discharge

___ Moodiness ___ Fibrocystic breasts ___ Breast tenderness

___ Ovarian cysts ___ Nipple discharge ___ Abnormal PAP smear

Family History

____ Asthma ____ Heart disease

____ Cancer ____ High Blood pressure

____ Diabetes ____ Stroke

Lifestyle

How is your diet? ___Great ___Good ___Fair

How many meals do you eat per day? _____ How many snacks? _____

Are you a vegetarian or a vegan? _____

What kind of foods make up your primary diet?

_____

_____

_____

What kinds of foods do you usually exclude from your diet?

_____

_____

_____

Do you exercise regularly? _____ What form? _____ How often? _____

Do you drink alcohol? ___Yes ___No How often? _____ How much? _____

Do you smoke? ___Yes ___No How much? _____

For how long have you been a smoker? _____

Do you use recreational drugs? ___Yes ___No What kind and how often? _____

How is your energy? ___ Great ___Good ___Fair ___Poor

How is your sleep? ___Great ___Good ___Fair ___Poor

How is your level of stress? ___ Low ___Moderate ___High

Source of stress: ___Work ___Financial ___Family/relationship ___other

Patient Signature_____ Date_____