

Date \_\_\_\_\_

**PINECREST WELLNESS CENTER**

**Provider: BILL REDDY, L.Ac.**

Patient's Name \_\_\_\_\_ Email \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ # of Children \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City State Zip

How did you hear about our office? \_\_\_\_\_

**STATEMENT OF UNDERSTANDING**

Massage (Tui Na), acupressure, acupuncture, cupping, gua sha, preventative or corrective exercise and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for western medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury. We recommend that you consult your physician for any serious conditions and get at least two medical opinions. It is your right and responsibility for your own body.

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

I understand that complications may result from acupuncture treatment. Among these possible complications are: Areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax and aggravation of present symptoms. Cupping may result in circular red or purple areas of skin that can last hours or days depending on the length of time the cups are in contact with the skin.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party Signature \_\_\_\_\_ Relationship \_\_\_\_\_

**CONSENT**

1. I authorize Bill Reddy, L.Ac. to perform all recommended treatment mutually agreed upon by me and to use the appropriate Chinese Herbal Medicine, supplements, and therapy indicated for such treatments.
2. I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.
3. Appointment cancellations must be made a minimum of 24 hours in advance or the appointment charge will be applied to the patient's account.

Please initial (acknowledgement of above): \_\_\_\_\_

Please List your Top 4 Chief Complaints:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

### MAJOR COMPLAINT, INJURY OR ILLNESS

Have you ever had this condition or similar condition before?  Yes  No  
Have you ever received treatment for this condition? If yes, when? By whom?

\_\_\_\_\_  
\_\_\_\_\_

What was the diagnosis? What were the results of the treatment?

\_\_\_\_\_  
\_\_\_\_\_

Has the condition gotten:  Better  Worse  About the same What makes it better?

\_\_\_\_\_  
\_\_\_\_\_

What makes it worse?

\_\_\_\_\_  
\_\_\_\_\_

Date began: \_\_\_\_\_ Describe what caused it or how it started:

\_\_\_\_\_  
\_\_\_\_\_

### FAMILY MEDICAL HISTORY

- |                                                     |                                          |                                           |                                         |                                      |
|-----------------------------------------------------|------------------------------------------|-------------------------------------------|-----------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Heart Trouble   | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Liver Disease  | <input type="checkbox"/> Eye Disease |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> TB              | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Ulcers         | <input type="checkbox"/> Arthritis   |
| <input type="checkbox"/> High/Low<br>Blood Pressure | <input type="checkbox"/> Allergies       | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Alcoholism  |
|                                                     | <input type="checkbox"/> Spinal Problems | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Drug Addition  |                                      |

Age parents died: Mother \_\_\_\_\_ Father \_\_\_\_\_

Personal Medical History: Major Surgeries – Illnesses – Diseases – Accidents (Include date)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Please attach a sheet if more space is required.

Contagious Diseases: (Check if you have ever had any of the following.)

- HIV  AIDS  Hepatitis  Venereal Disease  Herpes  
 Other: \_\_\_\_\_

Allergies: (Drugs, chemicals, food, animals, seasonal, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Medications/ Supplements presently taking:

\_\_\_\_\_  
\_\_\_\_\_

## LIFESTYLE

### Habits:

- Cigarettes       Soft Drinks       Salt       Coffee       Alcohol  
 Black Tea       Sugar       Stress       Recreational Drugs

### Exercise:

- Never       Little       Moderate       Heavy

### Emotionally:

- Happy       Easily Irritable       Angry       Cry easily       Depression  
 Stressed       Restless       Hurry to do things       Difficulty making decisions

### Diet (Typical Foods):

- Beef       Eggs       Cheese       Tofu       Pork       Bread       Margarine  
 Yogurt       Poultry       Milk       Ice Cream       Sweets       Fish       Butter  
 Vegetables       Salads       Hot Spicy Foods       Fried Foods       Health Foods

### Meals:

- Do you eat three meals per day?  Yes  No      Do you eat at regular hours?  Yes  No

### Appetite:

- Up and down       Poor       Good       Hungry a lot       Loss of taste

### Weight:

- Normal       Underweight       Overweight       Recent gain       Recent loss

### Energy:

- Up and down       Low       Normal       Excess       Low after eating       Tired in the afternoon

## General Symptoms

### Body Temperature:

- Warm natured       Flushed face       Feel Warmer late afternoon and night       Warm soles  
 Warm palms       Alternate chills and fever       Cold hands and feet       Cold natured  
 Normal       Other: \_\_\_\_\_

### Perspiration:

- Very little       Easily       Night sweats       Profuse       Palms       Without exertion  
 Bad smell       Normal       Other: \_\_\_\_\_

### Digestion:

- Indigestion       Nervous stomach       Bloating       Heartburn       Nausea       Vomiting  
 Full feeling or distention       Belch/ burp       Gallstones       Stomach noises       Weight Problems  
 Abdominal pain or cramps       Gas       Bad Breath       Difficulty digesting fatty or oily foods  
 Bitter taste in mouth       Normal       Other: \_\_\_\_\_

### Bowels:

- Loose stool       Blood in stool       Undigested food in stool       Diarrhea       Hemorrhoids  
 Constipation       Anus itch       Stool with bad smell       Mucous in stool       Colon problems  
 Burning anus       Black stool       Small amount of stool       Intestinal worms       Hard stool  
 Pain or cramps       Use laxatives       Normal       Other: \_\_\_\_\_

### Urination: (three to six times per day is normal)

- Frequent       Burning       Bladder infections       Urgency       Nighttime  
 Blood       Incontinence       Kidney stones or infections       Profuse       Pus  
 Strong smell       Cloudy       Normal color       Painful       Scanty  
 Normal       Other: \_\_\_\_\_

**Thirst:**

- Less than normal       Prefer Cold drinks       Thirsty but do not drink       Prefer hot drinks       Excessive
- Normal       Other: \_\_\_\_\_

**Sleep:**

- Difficulty falling asleep       Lots of dreams       Tired when get up in morning       Awake easily
- Nightmares       Sleep too much       Difficulty going back to sleep       Restless
- Normal       Other: \_\_\_\_\_

**Headaches – Dizziness:**

- Headaches       Vertigo       Poor balance       Dizziness       Faint easily       Poor memory
- Motion sickness       Migraines       Bend down/ stand up and get dizzy       Other: \_\_\_\_\_

**Skin:**

- Dry       Hives       Cuts heal slowly       Itchy       Warts       Yellow Skin       Oily
- Pimples       Eczema       Bruise easily       Boils       Rashes       Moles       Ulcers
- Body odor       Clammy       Normal       Other: \_\_\_\_\_

**Hair:**

- Dry       Oily       Falling out       Dandruff       Early grey       Normal
- Other: \_\_\_\_\_

**Nails:**

- Soft       Grow fast       Grow slowly       Purple       Pale       Ridges and lines
- Spots       Other: \_\_\_\_\_

**Eyes:**

- Wear glasses or contacts       Eyelids swollen       Cataracts       Red       Spots or lines in vision
- Inflammation       Glaucoma       Blink       Itch       Pale under eyelids
- Poor night vision       Yellow sclera       Twitch       Pain       Failing vision
- Sensitive to light       Sty history       Strain       Color Blindness       Tear easily
- Blurry vision       Normal       Other: \_\_\_\_\_

**Ears:**

- Poor hearing       Ringing (high pitch)       Discharges       Earaches       Ringing (low pitch)
- Normal       Other: \_\_\_\_\_

**Nose:**

- Stuffy nose       Hayfever       Sneeze a lot       Environmental sensitivity       Dry
- Loss of smell       Bleeding       Loss of smell       Blow nose a lot       Mucous
- Sinusitis       Rhinitis       Normal       Other: \_\_\_\_\_

**Mouth & Throat:**

- Dry       Gum problems       Hoarseness       Teeth problems       Frequent sore throats
- TMJ       Thyroid problems       Drool a lot       Swollen glands       Sores in mouth/tongue
- Grind teeth       Frequent colds       Dry/cracked lips       Difficulty swallowing       Feel lump in throat
- Hiccups       Normal       Other: \_\_\_\_\_

**Respiratory:**

- Shortness of breath       Difficulty inhaling       Sigh a lot       Chest pain       Difficulty exhaling
- Dry cough       Difficulty breathing       Asthma       Bronchitis       Cough with phlegm
- Cough with blood       Cough when lying down       Cough a lot       Tightness in chest
- Normal       Other: \_\_\_\_\_

**Cardiovascular – Circulation:**

- Diagnosed heart problems       Palpitations       Low blood pressure       Bleed easily
- Broken blood vessels/ capillaries       High blood pressure       High cholesterol
- Purple palms and fingers       Murmur       Varicose veins       Ankle swelling
- History of anemia       Chest pain       Facial swelling       Slow beating of heart
- Bruise easily       Hand swelling       Irregular heart beat       Numbness in extremities
- Normal       Other: \_\_\_\_\_

**Pain:**

- Neck             Shoulder       Elbow             Hands/wrists       Upper back       Mid back
- Low back       Hips             Sciatica         Muscle weakness  Muscle cramps    Muscle twitching/spasm
- Knees           Spine           Nerve            Foot or ankle     Damp weather     Arthritis
- Flank           Other: \_\_\_\_\_

Any Other Problems you would like to discuss?

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**FOR FEMALES ONLY**

- Are you or might you be pregnant?     Maybe    Yes    No      If yes, approximate date of conception? \_\_\_\_\_
- Are you experiencing reduced sex drive?       Yes    No
- Do you have regular pap tests?               Yes    No      How regular? \_\_\_\_\_
- Do you have regular breast exams?           Yes    No      How regular? \_\_\_\_\_
- Do you have facial hair or excess body hair?     Yes    No
- Other difficulties?                               Yes    No      Explain: \_\_\_\_\_

**Menstrual Cycle: (Please check and explain as applicable)**

- Age started: \_\_\_\_\_      Days of flow: \_\_\_\_\_      Age stopped: \_\_\_\_\_
- How many days from the beginning of your period to the start of your next period? \_\_\_\_\_
- Irregular     Painful       Heavy flow     Scanty flow     Dark color flow     Light color flow
- Clotting     Backache     Constipation    Diarrhea       Water Retention     Abdominal bloating
- Breast lumps    Painful/tender breasts     Spotting between period     Emotional changes
- Sigh a lot     Lump in throat feeling     Tightness in chest             Hormonal problems
- Other: \_\_\_\_\_

Vaginal Discharges:     Yellow       Thick       Bad Odor     White       Clear

Other: \_\_\_\_\_

Ovulation Symptoms: \_\_\_\_\_

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Menopause problems: \_\_\_\_\_

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Pregnancies:    Total number \_\_\_\_\_    Number of miscarriages \_\_\_\_\_    Number of children \_\_\_\_\_

Number of abortions \_\_\_\_\_

Pregnancy or childbirth complications: \_\_\_\_\_

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Gynecological history and operations:

- Ovaries: \_\_\_\_\_                               Uterus: \_\_\_\_\_
- Vagina: \_\_\_\_\_                               Fallopian tubes: \_\_\_\_\_
- Breasts: \_\_\_\_\_                               Other: \_\_\_\_\_

What method of birth control do you now use? \_\_\_\_\_

What method of birth control have you used in the past? \_\_\_\_\_

## FOR MALES ONLY

Please check or explain if applicable:

- |                                                         |                                                |                                            |                                          |
|---------------------------------------------------------|------------------------------------------------|--------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Reduced sex drive              | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Seminal emission  | <input type="checkbox"/> Impotence       |
| <input type="checkbox"/> Discharges                     | <input type="checkbox"/> Genital pain          | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Dribbling urine |
| <input type="checkbox"/> Pain or burning upon urination |                                                |                                            |                                          |

Explain: \_\_\_\_\_