grand rapids natural health

Grand Rapids Natural Health, LLC
Acupuncture of West Michigan
Stephen Durell, MTOM, R. Ac
www.grnaturalhealth.com

ACUPUNCTURE OF WEST MICHIGAN

638 Fulton St W Suite B
Grand Rapids MI, 49504
T (616) 264-6556
F (616) 432-3564

Personal Information

First Name:_____ Last Name: _____

Nickname: _____ Date:_____

Home Address:_____ City:_____

State:_____ Zip:_____ Home Phone: (_____)-_____-_____

Cell Phone: (_____) - _____-_____ Work Phone: (_____) - _____-_____ Ext___

Email Address:_____

Appointment Reminders: ___ Email ___ Text Message (Carrier _____) ____ Text and Email

Date of Birth:____/____/_____ Gender: M F

Marital Status: Single Married Partnered Divorced Widowed

Height:_____ Weight:_____ Occupation:_____

Have You Received Acupuncture Before: Yes No When:_____

How Did You Hear About Us:_____

In Case of Emergency Contact: Name:_____

Phone: (_____)-_____-_____ Relationship_____

Reason for Visit

Please list the reason or reasons you are seeking acupuncture today in order of importance. Please note that it is not always possible to address all conditions in one visit.

Condition	**Past Treatment (Medications, Surgery, Etc.)**
1._____	4._____
2._____	5._____
3._____	6._____

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Please list all of the medical providers involved in your care for the above condition.

1._____

2._____

3._____

Lifestyle

Please indicate the use and frequency of the following:

	Yes	No	How Often
Coffee/Black Tea	____	____	_____
Recreational Drugs	____	____	_____
Tobacco	____	____	_____
Alcohol	____	____	_____

	Yes	No	How Often
Soda Pop	____	____	_____
Exercise	____	____	_____
Antacids	____	____	_____
Laxatives	____	____	_____

Do You Typically Eat Three Meals A Day?: Yes No If No How Many:_____

How Many Hours Per Night Do You Sleep?:_____ Is It Easy For You To Fall Asleep?: Yes No

Do You Wake Up During The Night?: Yes No Do You Wake Feeling Rested?: Yes No

How Many Hours Per Week Do You Work?:_____ Do You Enjoy Work?: Yes No

Medical History

Please note if you or an immediate family member are currently or have ever experienced any of the below diseases.

Illness	You	Relative
Cancer	_____	_____
High Blood Pressure	_____	_____
Emotional Disorders	_____	_____
Seizures	_____	_____

Illness	You	Relative
Diabetes	_____	_____
Heart Disease	_____	_____
Stroke	_____	_____

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Do You Currently Have Any Infectious Diseases: Yes No If Yes, What Disease:_____

Do You Have Any Known Allergies: Yes No If Yes, To What:_____

Are You Taking Coumadin or Warfarin: Yes No Do You Have A Pacemaker: Yes No

Please list any medications (prescribed or over the counter), vitamins, supplements, or herbs you are currently taking or have taken in the last year.

Medication	Dosage	Reason	How Long	Prescribed By

Blood Pressure:_____/_____ Month And Year Blood Pressure Was Last Checked:_____/_____

Men Only

Date Of Last Prostate Check Up:_____/_____

Please Circle Any Symptoms That You Experience:

Erectile Dysfunction (ED)

Delayed Urinary Stream

Changes in Libido or Sexual Function

Decreased Force Of Stream

Genital Discharge

Genital or Groin Pain

Urinary Problems

BPH/Enlarged Prostate

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Women Only

Are You Or Could You Be Pregnant: Yes No If Yes, How Far Along Are You:_____

Of Pregnancies:_____ # Of Live Births:_____

Age Of Last Period (Menopause):_____ Number Of Days Between Periods:_____

Number of Days Of Flow:_____ Color Of Blood:_____

Do You Have Clots In Your Flow: Yes No If Yes, What Is The Size Of The Clots:_____

Do You Have Heavy Flow: Yes No Do You Have Light Flow: Yes No

Have You Been Diagnosed With Any Of The Following (Please Circle If Yes):

Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts Pelvic Inflammatory Disease

Please Circle Any Symptoms That You Experience:

Vaginal Discharge

Premenstrual Nausea

Premenstrual Swollen Breasts

Poor Appetite Before Period

Poor Appetite During Period

Changes in Libido

Premenstrual Mood Swings

Ravenous Hunger Around Period Time

Headache Around Period Time

Changes in Bowel Frequency Around Periods

Hot Flashes

Vaginal Dryn