LIGHTHOUSE
YOGA & ACUPUNCTURE

GENERAL INFORMATION

Name ____________________

Address: street, city, state, ZIP ____________________

Phone: cell, home, work ____________________

Email address ____________________

Date of birth ________ Age ________ Ht ________ Wt ________

Marital status ________ Number of children ________

Occupation ____________________

Emergency contact: ________ phone ________ relation ________

How did you hear about Lighthouse Acupuncture? ____________________

May I thank them for referring you? ____________________

Primary care physician: ________ phone ________

Have you had acupuncture before? ____________________

What brings you in? ____________________

____

Have you received a diagnosis for these symptoms? Y/N. If yes, when and by whom? ____________________

____

Have you sought any other treatment for these symptoms/concerns? ____________________

What has been helpful for you in finding relief in the past? ____________________

What exacerbates the issue? ____________________

Are you currently on any medications or taking any herbs or supplements? Please list them below (including any that you have taken in the past 2 months) ____________________

____

____

Have you had any surgeries or serious injuries? When and for what reason? ____________________

____

Have you been hospitalized in the past? ____________________

Do you have any prosthetics, implants, metal devices, or a pacemaker? ____________________

To what extent do your health concerns interfere with daily life? (rate from 1–5, 5 being "greatly interferes") ____________________

Home life__ work__ sleep__ exercise__ social__ school__ Please explain ____________________

____

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DAILY LIFE AND HABITS

Do you follow any specific diet/nutritional regimen? (i.e. diabetic, vegan, gluten-free, dairy-free, low carb) ____________________

____

Do you have any allergies to food or otherwise (drug, chemical, food, substance)? Please list, along with reaction ____________________

____

How many meals do you eat per day? ____________________

Typical breakfast ____________________

Typical lunch ____________________

Typical dinner ____________________

Do you have any cravings (e.g. sweet, salty, or sour)? ____________________

How much water do you drink every day? ____________________

Coffee/day? ____________________ Tea/day? ____________________

What other beverages do you drink? ____________________

Alcohol/day or week? ____________________

Do you smoke? Y/N. If yes, how frequently? ____________________

Do you use non-medicinal drugs? Y/N. If yes, what kind and how frequently? ____________________

How many hours do you sleep? From ____________________ To ____________________

Are you currently working? Do you enjoy it? ____________________

What is your stress level? (1–10, 10 is highest) ____________________

How much does your stress impact your life? ____________________

What are the stressors in your life? ____________________

Do you exercise? How much and what type? ____________________

GOALS

What would you like to accomplish through treatment? List in order of importance.

____

____

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FAMILY HEALTH HISTORY

Past medical history and family medical history. Does this condition apply to you or a family member? Please specify which relative (mother, father, sibling, etc.) as well as approximate date of diagnosis.

- Cancer (specify type) ☐ ______
- Diabetes ☐ ______
- Tuberculosis ☐ ______
- Thyroid disease ☐ ______
- HIV/AIDS ☐ ______
- Heart disease ☐ ______
- Hypertension ☐ ______
- Stroke ☐ ______
- High cholesterol ☐ ______
- Digestive disorders ☐ ______
- Hepatitis ☐ ______
- Mental illness ☐ ______
- Venereal disease ☐ ______
- Arthritis ☐ ______
- Fibromyalgia ☐ ______
- Auto-immune ☐ ______
- Asthma ☐ ______
- Alcoholism ☐ ______
- Anemia ☐ ______
- Other (explain) ☐ ______

PLEASE NOTE:
Check current conditions and
Circle former conditions

General Symptoms

- ☐ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Weight loss
- ☐ Forgetfulness
- ☐ Numbness or pain in arms, hands, joints, legs, or feet
- ☐ Confusion
- ☐ Paralysis

Eyes, Ears, Nose, & Throat

- ☐ Failing vision
- ☐ Near sightedness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cross eyed
- ☐ Eye inflammation
- ☐ Glaucoma
- ☐ Deafness
- ☐ Earache
- ☐ Hearing loss
- ☐ Ear discharge
- ☐ Ear ringing
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Nasal drainage
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Hay fever
- ☐ Allergies
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Difficult swallowing
- ☐ Loss of taste
- ☐ Teeth grinding/TMJ
- ☐ Dental decay/gums
- ☐ Dry mouth
- ☐ Tonsillitis
- ☐ Asthma
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Enlarged glands

Skin

- ☐ Rosacea
- ☐ Acne
- ☐ Dryness
- ☐ Itching
- ☐ Bruise easily
- ☐ Boils
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives or allergies

Respiratory

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Wheezing

Cardiovascular

- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Irregular heartbeat
- ☐ Pain over heart
- ☐ Previous heart stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Varicose veins
- ☐ Pacemaker
- ☐ Stent

Muscles and Joints

- ☐ Stiff neck
- ☐ Pain between shoulders
- ☐ Backache
- ☐ Painful tailbone
- ☐ Foot trouble
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Swollen joints
- ☐ Stiff joints
- ☐ Painful joints
- ☐ Arthritis
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

Genitourinary

- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection or stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostrate issues
- ☐ Foul smelling urine
- ☐ Discolored urine

Gastrointestinal

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Gas
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Distention of abdomen
- ☐ Diarrhea
- ☐ Black stool
- ☐ Blood in stool
- ☐ Colon trouble
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble

Female

- ☐ Painful periods
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycles
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Congested breast
- ☐ Breast pain
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding
- ☐ Reduced sexual energy
- ☐ Pregnancy
- ☐ Pregnancy complications

Male

- ☐ Painful/swollen genitals
- ☐ Reduced sexual ability/ desire
- ☐ Excessive sexual desire
- ☐ Weak erection
- ☐ Premature ejaculation
- ☐ Seminal emission
- ☐ Low sperm count
- ☐ Impotence
- ☐ Frequent masturbation
- ☐ Swollen/itching scrotum
- ☐ Low sperm count
- ☐ Poor morphology
- ☐ Poor motility
- ☐ Testicular pain
- ☐ Urethra pain/discharge
- ☐ Genital odor

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