Patient Information

Patient Information

First:_____ Middle:_____ Last Name_____

Nickname: (if applicable) _____ Date of Birth: _____ o Male o Female

Social Security #: _____Marital Status: Single Married Separated Divorced Widow Other

Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Employer: _____ Preferred Method of Contact: Phone Email Mail

Cell Phone: _____ Home Phone _____Work Phone_____

Email Address: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Insurance Information

Insurance Carrier: _____ ID #: _____

Group #: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Relationship to patient: _____

Primary Care Physician

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Name of Referring Medical Professional (If applicable)

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Intake Questionnaire

What are the concerns for which you are seeking care? (Symptoms and date of onset)

1. _____
_____
2. _____
_____
3. _____
_____

What treatments have you received for any of these conditions and what were the outcomes?
_____

What makes your condition better? (Exercise, rest, heat, cold, eating, sleeping, etc)
_____

What makes your condition worse? (Fatigue, stress, certain foods, time of day, heat, cold, etc.)
_____

Did your problem begin?

____After a specific event ____After multiple incidents ____Gradually, over time

____No specific reason noted

Exercise, Energy and Sleep:

How much exercise per week _____

How is your energy level? _____

When is it lowest? _____Highest? _____

How many hours per night do you normally sleep? _____

I have difficulties with (check all that apply):

____Falling asleep ____Staying asleep ____Dream-disturbed sleep

____Waking up at about ____am/pm and not being able to fall back asleep

Typical Diet:

Please list your normal meals, snacks and beverages

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Do you have cravings and if so, for what? _____
How much water do you drink daily? _____ Do you prefer warm or cold drinks? _____
Are you excessively thirsty?_____

Symptoms:

Check any symptoms you currently experience and star ones you have had in the past (next page)

GENERAL

____ Poor or Change in Appetite
____ Poor Sleep
____ Fatigue / Low Energy
____ Fevers
____ Chills
____ Cravings
____ Bleed/Bruise Easily
____ Night Sweats or Hot Flashes
____ Sweat Easily
____ Colder than those around you
____ Warmer than those around you
____ Weight loss or gain
____ Libido Low, Med or High
____ High Stress

NOSE AND SINUSES

____ Frequent Colds
____ Nose Bleeds
____ Sinus Congestion
____ Frequent Runny Nose
____ Hay Fever
____ Sinus Problems
____ Loss of Smell

IMMUNE

____ Chronic Fatigue Syndrome
____ Chronic Infections
____ Chronically Swollen Glands
____ Slow Wound Healing

HEAD / NECK

____ Headaches
____ Migraines
____ Jaw Pain
____ Teeth Grinding
____ Swollen Glands
____ Goiter
____ Recurrent Sore Throats/Colds

SKIN

____ Rashes
____ Eczema or Psoriasis
____ Acne, Boils
____ Redness of Skin
____ Itching
____ Fungal Infections
____ Skin Discoloration
____ Hair Loss
____ Dry Skin/Scalp
____ Greasy Hair
____ Change in Hair texture
____ Night Sweats
____ Slow healing ulcerations
____ Weak or ridged nails
____ Recent Moles

MOUTH AND THROAT

____ Sore Throat
____ Copious Saliva
____ Teeth Grinding
____ Sore Tongue/Lips
____ Gum Problems
____ Hoarseness

RESPIRATORY

____ Chest Congestion
____ Chest Tightness
____ Asthma
____ Difficulty inhale/exhale
____ Phlegm…what color ?
____ Cough ___ Wet or ___ Dry
____ Coughing Blood
____ Bronchitis
____ Pneumonia

NEUROLOGIC

____ Seizures or Tremors
____ Paralysis
____ Muscle Weakness
____ Numbness or tingling
____ Easily Stressed
____ Vertigo or Dizziness
____ Loss of Balance

CARDIOVASCULAR

____ Chest Pain or Pressure
____ Shortness of Breath
____ Irregular Heart Beat
____ Palpitations at Rest
____ Blood Clots
____ Irregular Heart Beat
____ Palpitations/ Fluttering
____ Swelling of Hands or Feet

EYES AND EARS

____ Itchy Eyes
____ Watery Eyes
____ Dry Eyes
____ Swollen/painful eyes
____ Red Eyes
____ Blurred Vision
____ Spots in Front of Eyes
____ Cataracts
____ Color Blindness
____ Double Vision
____ Glaucoma
____ Hearing Difficulty
____ Ringing
____ Earaches/ Infection

DIGESTION

____ Abdominal Pain/Cramps
____ Trouble Swallowing
____ Heartburn/Acid Reflux
____ Change in Appetite/Thirst
____ Nausea
____ Vomiting
____ Gas/Bloating
____ Belching or Passing Gas
____ Diarrhea
____ Constipation
____ Pain or Cramps
____ Mucous in Stools
____ Black/Bloody Stool
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong Smelling Stools
____ Food in Stools
____ IBS
____ Crohns

Bowel Movements

____How Often?

Stools

___ Hard ___ Firm
___ Soft ___ Loose (> 2 / day)

CIRCULATION

____ Faintness
____ Dizziness
____ Easy Bleeding or Bruising
____ Anemia
____ Deep Leg Pain
____ Varicose Veins
____ Cold hands/feet
____ Spontaneous Sweating

ENDOCRINE

____ Hypothyroid
____ Heat or Cold Intolerance
____ Hypoglycemia
____ Diabetes
____ Excessive Thirst
____ Excessive Hunger
____ Seasonal Depression

MENTAL / EMOTIONAL

____ Mood Swings
____ Anxiety or Nervousness
____ Depression
____ Poor Concentration
____ Poor Memory
____ Angry Outbursts
____ Weepy
____ Sadness

MUSCLE / JOINT / BONES

____ Neck Pain
____ Jaw Pain
____ Shoulder Pain
____ Arm/Wrist Pain
____ Knee Pain
____ Back Pain: Low Middle Upper
____ Sciatica
____ Heaviness of Limbs
____ Muscle Pain/Tension
____ Muscle spasms / cramps
____ Restless Leg Syndrome
____ Weak/Sore Lower Body
____ Areas of Numbness
____ Loss of Stregth
____ Tingling Sensations

GENITO-URINARY

____ Pain/Burning when urinating
____ Frequent Urination
____ Dark or Pale Yellow
____ Cloudy Urine
____ Night Urination
____ Copious or Scanty Urination
____ Inability to hold Urine
____ Urinary Tract Infections
____ Kidney Stones
____ Blood in Urine

MALES ONLY

____ Hernias
____ Testicular Masses
____ Testicular Pain
____ Varicoceles
____ STD

FEMALE ONLY

____ Premature Ejaculation
____ Prostate Disease
____ Sexually Transmitted Disease
____ Irregular Cycles
____ Bleeding between Cycles
____ Pain during Intercourse
____ Clotting
____ Heavy or Excessive Flow
____ PMS
____ Painful Menses
____ Vaginal Discharge - Color
____ Vaginal Itching/Burning
____ Vaginal Odor
____ Menopausal Symptoms
____ Vaginal Dryness
____ Sexually Transmitted Disease
____ Breast Pain / Tenderness
____ Nipple Discharge
____ Breast Lumps
____ Discharge or Sores
____ Sexual Dysfunction
____ Infertility

Acupuncture Patient Consent Form

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

Notice to pregnant women: All female patients must inform the clinician if they know or suspect they are pregnant as some procedures and therapies described herein may present a risk to the pregnancy.

I, _____ understand that Flex5 Wellness I may receive any or all of the following: Acupuncture, Cupping, Electric Stimulation, Gua Sha Massage, Bleeding, and Petro Fitness, LLC (dba Flex5 Wellness) recommendations. The availability of alternate treatment options have been explained to me. I have also been advised of the possible consequences if I decline care. I understand there is no guarantee of any specific result from the care I receive at PetroFitness, LLC.

Acupuncture is a generally safe method of treatment, but it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and scarring are a potential risk of moxibustion and cupping, or when treatment involves the heat lamp. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

Patient Signature _____ Date _____

Print Name _____

Parent or Guardian of a minor child _____