Sweet Relief Acupuncture

CONSULTATION HISTORY

Patient's Name
_____Date_____

Address
_____City_____State_____Zip_____

Home Phone _____Cell phone_____Contact preference_____

Email Address
_____

Birthdate _____ Height _____Weight_____

Are you? ___Single ____Married _____Student

Insurance
company_____

Emergency contact:
_____Phone:_____

How did you hear about us?
_____

MAJOR
COMPLAINT_____

How long has this been going on?_____

How often does it occur?_____

(Secondary
complaint)_____

Regarding this second problem: How long has it been going on? _____
How often does it occur?_____

Before you noticed these problems, were there any earlier accidents, injuries or physical stresses that may or may not have been directly related to this problem that you remember? Let us begin with the most severe. (Example: fall, auto injury, work injury, sports trauma, repetitive motion on the job, sitting at a computer for hours, etc.)

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

Sweet Relief Acupuncture, LLC
Leanne Pusateri, L.Ac.
4121 S Meridian, Suite 1-C
Puyallup, WA 98373
253-468-0596

5. _____

6. _____

Since the time you first had these problems, what, if anything, have you tried that did not work permanently? (Example: ice, heat, rest, over the counter meds, prescription meds)

_____

_____

_____

Have any of these treatments helped your health problem? [ ] Yes [ ] No

Is there any other health problem(s) that concern you besides your major complaint even if you never considered an acupuncturist could help? For example, do you have any sinus problems, hormone problems, asthma, diabetes, digestive troubles, arthritis, fatigue, mood swings, stress or anxiety attacks, troubles with sleep or any other problems at all that you wish you could get rid of? How does it affect your activities or mood?

_____

_____

I am now going to ask you some questions about these problems so that we can better measure your progress and the benefits of our care in the future.

How do your health problems affect your job performance?

_____

Are you less productive on your job because of your health problems? [ ] Yes [ ] No
Do you enjoy your work less because of your health problems? [ ] Yes [ ] No
Do you have to take more breaks? [ ] Yes [ ] No

What hobbies or interests do you have outside of work?

_____

_____

Do your health problems affect your hobbies/interests? [ ] Yes [ ] No

Because healing occurs when you are asleep, and sleep Is essential to health and immunity, I wanted to ask you about your sleep.

Do you have:
1. Trouble falling asleep due to being uncomfortable? [ ] Yes [ ] No
2. Not enough restful sleep? [ ] Yes [ ] No
3. Awakening in the middle of the night? [ ] Yes [ ] No
4. Waking earlier than you normally would? [ ] Yes [ ] No

Are there any other comments or concerns regarding your health you would like to mention?

_____

_____

_____

_____

Patient goals for treatment:

1._____

2._____

3._____

4._____

What Medications are you currently taking?

_____

_____

_____

What over-the-counter supplements are you taking?

_____

_____

_____