

Yampa Valley Acupuncture & Chinese Herbs

57 10th Street, Suite 1A, Steamboat Springs, CO 80487 • 970-819-6738

Welcome to Yampa Valley Acupuncture & Chinese Herbs. Please complete this form to help me provide you with the best possible care. All information will remain confidential.

Name:	Date:	
Gender: F M	Social Security #:	
Date of Birth:	Marital Status: S M W D	
Mailing Address Street or P.O. Box:		
City:	State:	Zip:
Physical Address Street:		
City:	State:	Zip:
Phone #:	Email address:	
Occupation:	Employer:	
Emergency Contact Name:	Relationship:	
Phone #: Address:		
Physician's Name:		
Phone #:		
Health Insurance Company Name:		
Phone #:		
Your Policy #:		
Have you received acupuncture or Chinese herbs in the past? Y N		

How did you hear about this clinic?

Reason for today's visit:

This condition is due to: Work injury Auto Injury
 Sports injury Illness
 Other

Auto Insurance Co. handling case:

Worker's compensation claim manager:

Case number:

When did your symptoms begin?

How long do your symptoms last?

Is there a pattern when your symptoms occur? If yes, please describe:

What initiates your symptoms?

What makes this problem feel better?

What makes this problem feel worse?

Are you being treated elsewhere for this condition?

Y

N

If yes, by whom?

Please list any prescription medications you are taking:

Please list any herbs or supplements you are taking:

Please list any medications you are allergic to:

Please check all boxes that are now or have been part of your health history:

- | | | |
|--|---|---|
| <input type="checkbox"/> Addiction (drugs/alcohol) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid Disorders |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Injuries | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Insomnia | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal Parasites | _____ |
| <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> Emotional Difficulties | <input type="checkbox"/> Multiple Sclerosis | _____ |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | _____ |

Please list any surgeries you have had, including date:

Please list any serious accidents you have had, including date:

Have you had any serious illness in the past? If yes, describe:

How was your health as a child?

Family Health History

Please check any conditions that have occurred in any blood relatives:

- | | | |
|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other: |

Father Living, Age:_____ Deceased, Age:_____ Cause:_____

Mother Living, Age:_____ Deceased, Age:_____ Cause:_____

Spouse Living, Age:_____ Deceased, Age:_____ Cause:_____

Siblings #:_____ Health Status:_____

Children #:_____ Health Status:_____

Please describe your typical daily diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Please describe your exercise routine:

Are you currently under any unusual stress?

Which of the following are part of your lifestyle:

- | | | |
|----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Supplements |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Meditation/Relaxation | |

Women Only

Age of first menstruation:

Age at menopause:

Date of first day of last menstrual period:

Number of days of bleeding:

Length of monthly cycle:

Are your periods: Heavy Light Normal flow

Are your periods irregular? Y N If yes, describe:

Are your periods painful? Y N What relieves pain?

What is the color of blood?

Dark Red Light Red Purple Brown Red

What is the consistency of the blood?

Thick Watery Clotted Normal

Do you experience spotting? Y N If yes, when?

Once your period starts, does it stop & then start again? Y N

Do you experience PMS? Y N If yes, please check the appropriate boxes:

- | | | |
|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Painful, swollen breasts | <input type="checkbox"/> Cramps | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Nausea | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Depression, crying | <input type="checkbox"/> Bloating | |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Diarrhea | |

Vaginal Discharge:

- | | |
|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Clear |
| <input type="checkbox"/> Watery | <input type="checkbox"/> Bad odor |
| <input type="checkbox"/> Thick | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Yellow | <input type="checkbox"/> Dry |
| <input type="checkbox"/> White | <input type="checkbox"/> Other: |

Have you had any gynecological surgeries or problems? Y N

If yes, please describe:

Pregnancies

Total #: _____

of children: _____ Ages: _____

of miscarriages: _____

Complications: _____

Men Only

Please check any of the following symptoms you experience:

- | | |
|--|---|
| <input type="checkbox"/> Reduced libido | <input type="checkbox"/> Genital discharge |
| <input type="checkbox"/> Excessive libido | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Impotence | |

System Review

Please put one check mark by a symptom that you occasionally experience, two checks for those that occur often, and three checks by any symptom that is a major concern to you.

Head & Face

- Headaches
- Dizziness
- Memory loss
- Other: _____

Eyes

- Blurry vision
- Red, itchy
- Floaters
- Pain
- Poor eyesight
- Other: _____

Ears

- Ringing
- Excessive ear wax
- Earaches
- Hearing difficulty
- Other: _____

Nose

- Frequent colds
- Sinus infection
- Bleeding
- Loss of smell
- Allergies

Mouth

- Bleeding gums
- Tooth decay
- Jaw tension
- Tongue problems
- Unusual tastes
- Loss of taste

Throat

- Sore throat
- Hoarseness
- Difficulty swallowing
- Other: _____

System Review

Respiratory

- Difficulty inhaling
- Difficulty exhaling
- Frequent lung infections
- Chest congestion
- Cough
- Asthma
- Other:

Cardiovascular

- Palpitations
- High blood pressure
- Tightness in chest
- Chest pain
- Low blood pressure
- Easy bleeding
- Easy bruising
- Cold limbs, hands, feet
- Hot palms or soles
- Other:

Gastrointestinal

- Excessive hunger
- Low appetite
- Excessive thirst
- No thirst
- Abdominal pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Gas or bloating
- Other

Skin

- Rashes
- Acne
- Dryness
- Night sweats
- Excessive sweating
- Rarely sweat
- Moles that change
- Other:

Urination

- Frequent
- Burning
- Difficult
- Painful
- Incontinence
- Blood in urine
- Other:

Neurological

- Seizures
- Numbness
- Tingling
- Nerve pain
- Lack of coordination
- Other:

Psychiatric

- Anxiety
- Depression
- Mania
- Paranoia
- Other:

Sleep

- Insomnia
- Wake frequently
- Vivid dreams
- Always sleepy
- Other:

Energy Level

- High
- Low
- Normal
- Other:

Musculoskeletal

- Joint pain
- Weak muscles
- Muscle cramps
- Stiff muscles
- Osteoporosis
- Other:

Pain

Please describe:

I authorize treatment by Kelley McDanel, a licensed acupuncturist at Yampa Valley Acupuncture & Chinese Herbs. All info on this form is correct to the best of my knowledge. I understand that I am responsible for all fees to Yampa Valley Acupuncture & Chinese Herbs on the day services are rendered.

Patient signature_____ Date_____

Consent to treat a minor: I hereby authorize Yampa Valley Acupuncture & Chinese Herbs to administer treatment to my child, _____
(child's name)

Parent/Legal Guardian signature_____ Date_____