



# Patient Introduction

Today's Date \_\_\_\_\_

## General Information

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient Sex: *M F* Marital Status: *S M W D* Number of Children \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Patient E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

**Are you or have you ever been a member of Eastpointe Health and Fitness (GYM)?  
YES or NO**

PLEASE TURN OVER

Describe your current complaint: \_\_\_\_\_

Have you ever had prior treatment for this issue? \_\_\_\_\_

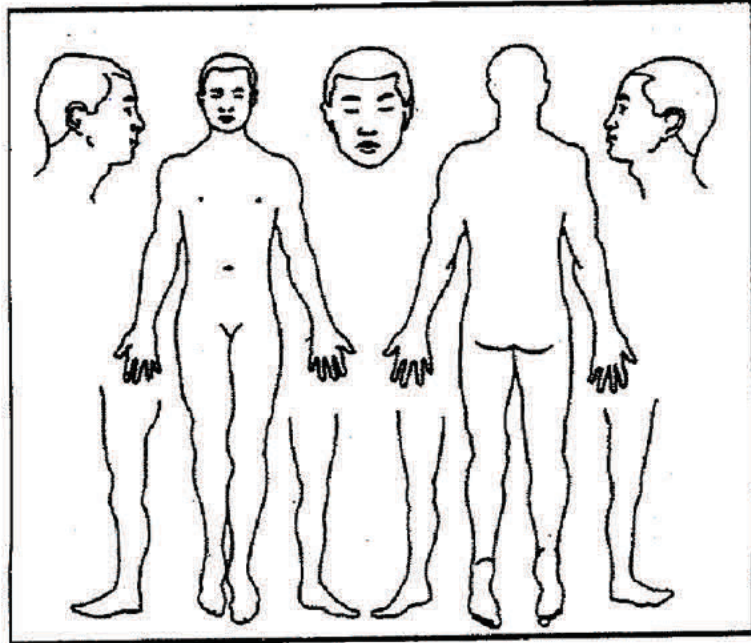
How did it begin? \_\_\_\_\_

How long have you had it? \_\_\_\_\_

Please rate your pain level  
1 2 3 4 5 6 7 8 9 10

Use the illustration to indicate  
painful or distressed areas.  
Indicate the location of the  
discomfort by using the symbol  
that best describes the feeling:

- X X X Sharp/Stabbing
- P P P Pins & Needles
- D D D Dull/Aching
- N N N Numbness
- T T T Tightness/Spasms



**Acupuncture Patients - skip the section below and proceed to page 2**

Below is a listing of symptoms, conditions or habits. Please check all that apply:

Symptom	Past	Present	Symptom	Past	Present		Past	Present
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use:	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use:	<input type="checkbox"/>	<input type="checkbox"/>
Arm/elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Condition	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine use:	<input type="checkbox"/>	<input type="checkbox"/>
Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy:	<input type="checkbox"/>	<input type="checkbox"/>
Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problem	<input type="checkbox"/>	<input type="checkbox"/>	Surgery:	<input type="checkbox"/>	<input type="checkbox"/>
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>	Please list _____		
Pain in upper leg or hip	<input type="checkbox"/>	<input type="checkbox"/>	Breast soreness/lump	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Pain in lower leg or knee	<input type="checkbox"/>	<input type="checkbox"/>	Sinus condition	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Pain in ankle or foot	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Swelling/stiffness of joints	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Excessive weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Skin Condition	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
General prolonged fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Prostate condition	<input type="checkbox"/>	<input type="checkbox"/>			
Condition of uterus/ovaries	<input type="checkbox"/>	<input type="checkbox"/>						