

# Avicenna Acupuncture

www.avicenna.us.com

1747 Marion St.  
Denver, CO 80218  
Phone: 303 803 0308

## ALL PATIENT'S INFORMATION WILL REMAIN CONFIDENTIAL

Name \_\_\_\_\_ Date \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Who should we thank for referring you to our office? \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_  
Your primary care physician -name and phone \_\_\_\_\_

Please indicate any illness you or a blood relative (grandparent, parent, sibling) have had:

	You	Your relative	Approx. Date
Cancer	_____	_____	_____
Hepatitis	_____	_____	_____
High Blood Pressure	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Infectious Diseases	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Seizures	_____	_____	_____
Emotional Disorders	_____	_____	_____
Tuberculosis	_____	_____	_____

STDS: Gonorrhea\_\_\_ Syphilis\_\_\_ HIV\_\_\_ HPV\_\_\_ Chlamydia\_\_\_ Herpes\_\_\_ Date

List any medications and supplements you are currently taking:

Medicine	Dosage	Prescribed by	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Patient's Name: \_\_\_\_\_

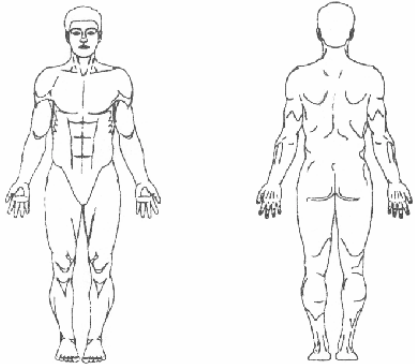
Please indicate frequency of the following:

	Yes	No	How Much		Yes	No	How much
Coffee	___	___	_____	Tobacco	___	___	_____
Water intake	___	___	_____	Drugs	___	___	_____
Alcohol	___	___	_____	Soda Pop	___	___	_____
Exercise	___	___	_____	Sugar	___	___	_____

What are the main problems for which you are seeking treatment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please mark the area of pain:



What other forms of treatment have you sought?

\_\_\_\_\_  
\_\_\_\_\_

List any other health concerns that you have:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any known allergies?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Patient's Name: \_\_\_\_\_

List any accidents, surgeries or hospitalizations (please include dates):

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How do you feel about the following areas of your life:

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	___	___	___	___	___	_____
Family	___	___	___	___	___	_____
Diet	___	___	___	___	___	_____
Sex	___	___	___	___	___	_____
Self	___	___	___	___	___	_____
Work	___	___	___	___	___	_____
Exercise	___	___	___	___	___	_____
Spirituality	___	___	___	___	___	_____

## Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:  
NO MARK = never experience CHECK MARK (✓) = sometimes experience PLUS SIGN (+) = frequently experience

- |  |   |
|--|---|
| <input type="checkbox"/> sudden weight loss              | <input type="checkbox"/> recent use of antibiotics      |
| <input type="checkbox"/> lack of appetite                | <input type="checkbox"/> eye problems                   |
| <input type="checkbox"/> excessive appetite              | <input type="checkbox"/> gall stones                    |
| <input type="checkbox"/> loose stool or diarrhea         | <input type="checkbox"/> soft and brittle nails         |
| <input type="checkbox"/> digestive problems, indigestion | <input type="checkbox"/> difficulty in making decisions |
| <input type="checkbox"/> nausea, vomiting                | <input type="checkbox"/> spasms or twitching muscles    |
| <input type="checkbox"/> belching, burping               | <input type="checkbox"/> knee problems                  |
| <input type="checkbox"/> heartburn, reflux               | <input type="checkbox"/> hearing impairment             |
| <input type="checkbox"/> insomnia                        | <input type="checkbox"/> ear ringing                    |
| <input type="checkbox"/> nightmares                      | <input type="checkbox"/> kidney stones                  |
| <input type="checkbox"/> heart palpitations              | <input type="checkbox"/> decreased sex drive            |
| <input type="checkbox"/> restlessness                    | <input type="checkbox"/> hair loss                      |
| <input type="checkbox"/> cold hands and feet             | <input type="checkbox"/> urinary problem                |
| <input type="checkbox"/> abdominal pain                  | <input type="checkbox"/> fatigue                        |
| <input type="checkbox"/> chest pain                      | <input type="checkbox"/> edema                          |
| <input type="checkbox"/> back pain                       | <input type="checkbox"/> easily bruised                 |

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- headaches
- pain or coldness in genital area
- cough
- shortness of breath
- decreased sense of smell
- nasal problems
- skin problems
- constipation
- hemorrhoids
- blood in the stools

- tendency to catch colds
- asthma
- intolerance to weather
- dizziness
- tendency to faint easily
- high cholesterol
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