Allen Acupuncture & Wellness, LLC| *6801 Lake Worth Rd Ste 101, Greenacres, FL 33467*
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New Patient Information

Name _____ Today's Date _____
Street Address _____ Unit _____
City _____ State _____ Zip _____
Preferred Phone _____ Email _____
Birth Date (include year) _____ Age _____
Gender _____ Marital Status _____Referred by _____
Emergency Contact: Name _____ Phone _____
Primary Care Physician: Name _____ Phone _____

Fees & Cancellation Policy:

It is our policy that you pay the entire session fee or co-pay at the time of each session. If you need to change or cancel your appointment please notify us within a minimum of 24 hours notice. Failure to do so will result in being charged $50 for your missed appointment.

☐ **I understand the cancellation policy.**

Signature:_____ **Date:** _____/_____/_____

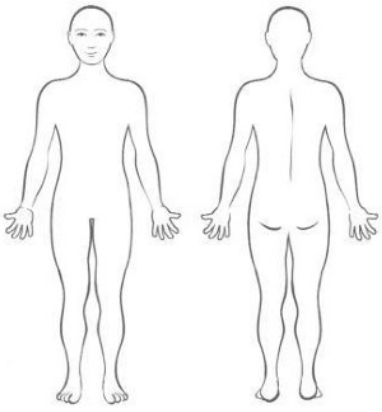
Health History:

Have you had acupuncture before? _____ If so, for what reason? _____

Main issue(s) you are seeking treatment for and length of time experiencing each: _____
_____
_____
_____

Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):
_____
_____
_____

What are your goals for your health? _____
_____
_____



Please mark any areas of pain or discomfort:

Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

_____
_____
_____
_____
_____
_____

Please check any SYMPTOMS that you have experienced in the past or currently experience:

	past	current		past	current
day/night sweating	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble sleeping	☐	☐
dizziness/vertigo	☐	☐	fevers/chills	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐
bleed or bruise easily	☐	☐	autoimmune disease	☐	☐
rashes/hives	☐	☐	psoriasis/eczema	☐	☐
dry/oily skin/acne	☐	☐	loss of hair/thinning hair	☐	☐
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing ears/hearing loss	☐	☐	pain behind the eyes	☐	☐
sinus pressure/stuffy nose	☐	☐	sneezing	☐	☐
nose bleeds	☐	☐	eye floaters	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision/vision loss	☐	☐	sore/swollen throat	☐	☐
heartburn/belching	☐	☐	gas/bloating	☐	☐
diarrhea	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus/blood in stool	☐	☐
chronic bad breath	☐	☐	hemorrhoids	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐
chest pain/tightness	☐	☐	swelling/edema	☐	☐
fainting/lightheadedness	☐	☐	high blood pressure	☐	☐
cold hands & feet	☐	☐	low blood pressure	☐	☐
palpitations/arrhythmia/murmur	☐	☐	shortness of breath	☐	☐
seasonal/other allergies	☐	☐	cough	☐	☐
phlegm production	☐	☐	asthma/wheezing	☐	☐
difficulty/painful urination	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores/painful genitals	☐	☐
STD/Hepatitis/HIV	☐	☐	yeast infections	☐	☐

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐

For Women Only:

irregular periods	☐	☐	breast pain	☐	☐
painful periods/cramping	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes/night sweats	☐	☐

age of first menses _____ duration of typical period _____
duration of typical cycle _____ age at menopause _____
# of pregnancies _____ # of live births (+ years) _____
# of miscarriages _____ # of abortions _____

Are you currently pregnant or breastfeeding? _____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.) _____

_____

_____

For Men Only:

erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate on any check marks:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

_____

_____

_____

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

_____

Current exercise routine:_____

_____

Do you or have you ever used tobacco, drugs, or drank alcohol heavily? If so, what and how often?

_____

_____

_____

Allergies (medications/foods/chemicals/etc.):

_____

_____

_____

_____

Do you have a Pacemaker? Please list any major surgeries/hospitalizations and approximate dates:

_____

_____

_____

_____

Please list any other relevant information or issues you would like to discuss:

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.