Kairos Acupuncture, Chinese Herbs, & Bodywork LLC
262-323-9022| kairosacupuncture@hotmail.com | acupuncturewestbend.com

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New Patient Information

Name ____ Today's Date ______________________

Street Address ____ Apt. ________________

City ____ State ______________ Zip ________________

Preferred Phone _________________________ Email ______________________________________

Birth Date (include year) _____________________ Age ____________ Gender _________________

Occupation _______________________________ Employer _________________________________

Referred by ____

Emergency Contact: Name __________________________ Phone ____________________________

(continued onto next pages)

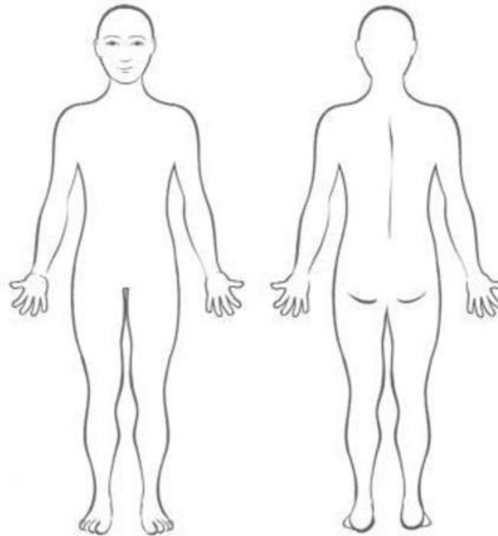
Health History

Have you had acupuncture before? __________ If so, for what reason? ___________________ Main issue(s) you are seeking treatment for: ____

____

Diagnosis from a medical professional (if applicable): __________________________________

Please mark any areas of pain or discomfort:



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

General

	past	current		past	current
sweating easily during the day	☐	☐	fatigue	☐	☐
night sweating	☐	☐	fevers	☐	☐
bleed or bruise easily	☐	☐	chills	☐	☐
change in appetite	☐	☐	weight loss/gain	☐	☐
dizziness/vertigo	☐	☐	poor sleep	☐	☐

Skin & Hair

	past	current		past	current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	loss of hair	☐	☐
acne	☐	☐			

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐			

Cardiovascular/Circulatory

	past	current		past	current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐			

Respiratory

	past	current		past	current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐			

Genito-Urinary

	past	current		past	current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐

Neurological/Psychological

	past	current		past	current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐			

Digestive

	past	current		past	current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

For Women Only:

	past	current		past	current
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses ____________ duration of typical period __________________

duration of typical cycle _____________ date of last PAP ____________________

# of pregnancies ___________________ # of live births (+ years) _____________

# of miscarriages ___________________ # of abortions ______________________

Have you been through menopause? Age? ____

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

For Women Only (continued):

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

____

____

____

For Men Only:

	past	**current**		**past**	**current**
erectile dysfunction/impotence	□	□	ejaculatory pain	□	□
varicocele	□	□	BPH	□	□

Lifestyle

Current medications/herbs/supplements:

____

____

____

____

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

____

____

____

____

Current exercise routine:

____

____

____

____

Do you use tobacco? If so, how often?

____

Do you drink alcohol? If so, how many drinks/week?

____

____

Are you currently taking any of the following medications? *(circle if yes and indicate how often)*

Advil/Motrin/Ibuprofen   Aleve/Naproxen   Bayer/Aspirin

Celebrex/Celecoxib   Prednisone/Prednisolone

Are you currently taking any other pain medications? If yes, list name and amounts per day:

____

____

____

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

____

____

____

Have you ever had a seizure? If yes, indicate date of last: ____________________

Please circle any significant illnesses and indicate date:

Cancer   Hepatitis   Diabetes

High blood pressure   Epilepsy   Heart Attack

Stroke   Ulcer Disease   Liver Disease

Colon Polyps   Other ________________

Please list any major surgeries/hospitalizations and approximate dates:

____

____

____

Family Medical History

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other ___________________

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.