VIBRANT LIFE
ACUPUNCTURE & INTEGRATIVE MEDICINE

Patient Information

Patient Name: _____

Date of Birth: _____ **Age:** _____ **Gender/Sex:** _____

Single: _____ **Married:** _____ **Separated:** _____ **Divorced:** _____ **Widowed:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____

Email:_____

Occupation: _____ **Employer:** _____

EMERGENCY CONTACT: Name & Relation: _____

Phone #: _____

How did you hear about us?: _____

Would like to learn additional health tips and join our newsletter? ☐ Of course I would! ☐ Not interested
(Promise there is some good stuff in it!)

I understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment or coverage. I understand that any outstanding account balances will be sent to collections after 90 days if payment has not been remitted.
An Eastern Medicine Practitioner in the State of South Carolina is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition has been diagnosed by your doctor and is not an emergency situation we will be happy to do so, so long as the condition has been diagnosed by your doctor and is not an emergency situation. If I decide want to alter my pharmaceutical regime in any way the I must consult my doctor before doing so. I have read the above and I understand and accept these policies.

Date: _____
Patient Signature: _____

Health History Questionnaire

Major Complaint(s):

- _____
- _____
- _____
- _____

How do these conditions affect your daily activities? _____

Why do you want this to be better?_____

Primary Physician: _____

Other physicians/therapists: _____

We find that when your ***healthcare providers are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. Is it okay if we contact the above healthcare providers to update them on the treatments you are receiving here? ❑ **YES PLEASE** ❑ **NO THANKS**

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

Supplements (vitamins, herbs, minerals, etc.): _____

Health History Questionnaire

List all hospital stays, surgeries, or major illnesses that you have had since birth	Year Occurred

Test	Year	Test Results
☐ Physical	_____	_____
☐ Blood Labs	_____	_____
☐ Mammogram	_____	_____
☐ Pap Smear	_____	_____
☐ Prostate	_____	_____

Please check if you have or had any of the following conditions

☐ Diabetes	☐ Syphilis	☐ Mumps	☐ Jaundice
☐ Heart Disease	☐ CVA (Stroke)	☐ Rheumatic Fever	☐ Hepatitis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Vein Condition
☐ Allergies	☐ Gonorrhea	☐ Bleeding Tendency	☐ Tuberculosis
☐ Meningitis	☐ Measles	☐ High Blood Pressure	☐ Chicken Pox
☐ Epilepsy	☐ HIV	☐ Nervous Disorder	☐ Polio
☐ Paralysis	☐ High Fever	☐ Mononucleosis	☐ Migraines
☐ Glaucoma	☐ Cancer	☐ Multiple Sclerosis	☐ Anxiety

Health History Questionnaire

Please check all the symptoms that you are currently experiencing or experienced in the last 6 months.

PAIN CONDITION QUESTIONS (*SKIP IF YOU DON'T HAVE PAIN*)

Where is your pain?: _____

What makes the pain better?

- ☐ **Soft pressure**
- ☐ **Hard pressure**
- ☐ **Cold**
- ☐ **Heat**
- ☐ **Exercise**
- ☐ **Rest**

What makes the pain worse?

- ☐ **Soft pressure**
- ☐ **Hard pressure**
- ☐ **Cold**
- ☐ **Heat**
- ☐ **Exercise**
- ☐ **Rest**

TOTAL BOXES CHECKED: _____

DESCRIBE YOUR PAIN

- ☐ **Sharp**
- ☐ **Fixed**
- ☐ **Burning**
- ☐ **Moving**
- ☐ **Cramping**
- ☐ **Aching**
- ☐ **Dull**
- ☐ **Tight**

TOTAL BOXES CHECKED: _____

LUNG SYSTEM

- ☐ **Cough**
- ☐ **Shortness of breath**
- ☐ **Asthma**
- ☐ **Frequent colds/flu**
- ☐ **Allergies**
- ☐ **Sleep Apnea**
- ☐ **Postnasal drip**
- ☐ **Smoke cigarettes (packs per day: _____)**
- ☐ **Grief**
- ☐ **Skin issues**

TOTAL BOXES CHECKED: _____

HEART SYSTEM

- ☐ **Anxiety**
- ☐ **Sweat when anxious or nervous**
- ☐ **Restlessness, fidgety**
- ☐ **Poor Memory**
- ☐ **Chest pain or discomfort**
- ☐ **Palpitations, fluttering, skipped beats**
- ☐ **Trouble falling and/or staying asleep**

TOTAL BOXES CHECKED: _____

SLEEP QUALITY

Total hours of sleep per night ____
Restless sleep? _____
Feel hot during the night? ____
What time do you go to bed? _____
How many times do you wake up? _____
Do you feel refreshed when you wake up? _____

Health History Questionnaire

SPLEEN SYSTEM

- ☐ Low appetite
- ☐ Loose stools
- ☐ Dizziness upon standing
- ☐ Abdominal bloating after meals
- ☐ Cold hands, fingers, nose
- ☐ Craves sugar
- ☐ Worry, Overthinking
- ☐ Bruise easily
- ☐ Prolapsed organs: _____
- ☐ Limbs feel weak or lacks strength

TOTAL BOXES CHECKED: _____

SMALL/LARGE INTESTINE SYSTEM

- ☐ Constipation
- ☐ Incomplete stools
- ☐ Foul smelling/odor
- ☐ Explosive evacuation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools
- ☐ Excessive wiping
- ☐ Push to initiate, not easy to go

TOTAL BOXES CHECKED: _____

STOMACH SYSTEM

- ☐ Burning sensation after eating
- ☐ Large appetite, excessive hungry
- ☐ Bad Breath
- ☐ Canker sores (mouth), sores on lips
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach pain (above your belly button)
- ☐ Vomiting/nausea

TOTAL BOXES CHECKED: _____

LIVER SYSTEM

- ☐ Frustration, irritability, grumpy, impatient
- ☐ Angers easily
- ☐ You frequently find yourself sighing
- ☐ Blush easily with emotions like anger/stress
- ☐ Feeling stressed out
- ☐ Blurry vision, red eyes, poor night vision
- ☐ Alternating diarrhea & constipation
- ☐ Bloating at end of day
- ☐ Pain under ribs
- ☐ Premenstrual Symptoms
- ☐ Wrinkle lines b/w eyebrows
- ☐ Headache at the top of the head
- ☐ Headache at temples
- ☐ Neck/Shoulder tension
- ☐ High-pitched ringing in ears
- ☐ Gallstones
- ☐ Seizures, Convulsions
- ☐ Lump in the throat
- ☐ Alcohol consumption (per day: _____)
- ☐ Recreational drug use (which: _____)

TOTAL BOXES CHECKED:_____

KIDNEY & BLADDER SYSTEM

- ☐ Lower back pain
- ☐ Knee pain
- ☐ Cold feet
- ☐ Cold knees
- ☐ Low libido
- ☐ Excessive hair loss
- ☐ Kidney stones
- ☐ Fear, Easily Startled
- ☐ Hearing loss or declining
- ☐ Tinnitus low pitch ringing
- ☐ Easily broken bones
- ☐ Frequent cavities, teeth problems

TOTAL BOXES CHECKED: _____

URINATION (BLADDER FUNCTION)

- ☐ History UTI's, last time was _____
- ☐ Cloudy
- ☐ Scanty, small amount urine
- ☐ Burning or painful
- ☐ Urgency
- ☐ Difficulty
- ☐ Abnormal color: dark yellow, reddish
- ☐ Profuse amount
- ☐ Strong odor
- ☐ Night time urination, ___ times per night
- ☐ Too frequent like >10x/day
- ☐ Dribbling, leaking

TOTAL BOXES CHECKED: _____

VITAL SUBSTANCES

- ☐ Run warm or hot
- ☐ Face is red
- ☐ Very thirsty, guzzle water down
- ☐ Sweaty
- ☐ Feel warm only in afternoon/evening
- ☐ Cheeks feel flushed afternoon/evening
- ☐ Dry mouth/throat
- ☐ Night sweats
- ☐ Night time: hot chest, feet, or hands
- ☐ Thirsty but only sips drinks
- ☐ Always feel cold
- ☐ Prefer to drink warm liquids
- ☐ Low libido
- ☐ Muscle cramps/spasms
- ☐ Numbness/tingling
- ☐ Twitching
- ☐ Body feels heavy
- ☐ Edema/swelling
- ☐ Oily skin/scalp
- ☐ Mucus/phlegm
- ☐ Dryness: skin, hair, lips, mouth, eyes

TOTAL BOXES CHECKED: _____

MENSTRUAL CYCLE SYMPTOMS

- ☐ **Cramps sharp pain**
- ☐ **Cramps dull pain**
- ☐ **Food cravings**
- ☐ **Water retention**
- ☐ **Breast swelling**
- ☐ **Breast tenderness**
- ☐ **Headaches/migraines**
- ☐ **Irritability**
- ☐ **Depressed, sad, cry easily**
- ☐ **Other:**_____

TOTAL BOXES CHECKED: _____

Number of children ____ Number of pregnancies _____ Age of first menses _____
Date of start of last menses _____ How many total days is your cycle (ex.28 days total)? _____
Bleed for _____ days Pain during bleeding _____ Describe your flow _____

MEN ONLY

- ☐ **Swollen testes**
- ☐ **Testicular pain**
- ☐ **Impotence**
- ☐ **Premature ejaculation**
- ☐ **Coldness or numbness external genitalia**
- ☐ **Other: _____**

TOTAL BOXES CHECKED: _____

Nutrition

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Type of Diet:_____

Current weight: _____ Height:_____