**BLESSING ACUPUNCTURE**
RIKKE BLESSING, MS, L.AC.
831-333-1434
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# Patient Information

Name: _____

Address: _____

Home Phone:_____ Work Phone:_____

Email:_____ Preferred method of contact: ☐ Work ☐Home ☐Email

Date of Birth: _____Gender: ☐Female ☐Male

Emergency Contact:_____ Phone Number:_____

Are you currently taking any medication/drugs/herbs/ supplements: ☐Yes ☐No

If yes, please specify: _____

Do you have a family history of any of the following conditions:

☐Cancer ☐Diabetes ☐Allergies ☐Heart Disease ☐High Blood Pressure ☐Stroke ☐Other

Please specify:_____

Have you ever had or do you currently suffer from any of the following conditions:

☐Cancer ☐Diabetes ☐Allergies ☐Heart Disease ☐High Blood Pressure ☐Stroke ☐Hepatitis ☐AIDS
☐High Cholesterol ☐Asthma ☐Thyroid disorder ☐Diabetes ☐Immune disorders ☐Other

Please specify:_____

Are you pregnant: ☐Yes ☐No Are you trying to conceive: ☐Yes ☐No

**For insurance purposes only:**

Name of Insurance Company _____
Address:_____
Phone:_____

Member ID: _____ Employer: _____

**Main Complaint:** _____

Date of onset:_____ How long have you had this condition: _____

Have you had this in the past: ☐Yes ☐No
When:_____

Is this condition: ☐Improving ☐Constant ☐Getting Worse

What makes it feel better: ☐Heat ☐Cold ☐Movement ☐Rest ☐Don't know ☐Other
Please specify:_____

What makes it feel worse: ☐Heat ☐Cold ☐Movement ☐Rest ☐Don't know ☐Other
Please specify:_____

Is the pain: ☐Mild ☐Moderate ☐Severe
On a scale from 1(best) to 10(worse) the pain is_____

**Supplemental Information:**

**Energy level**
☐High (time of day)_____
☐Low (time of day)_____
☐Feel sleepy after eating

**Temperature**
☐Feel cold easily
☐Cold feet (time of day) _____
☐Cold hands(time of day)_____
☐Chills
☐Feel hot easily
☐Hot flashes (time of day) _____
☐Burning sensation in ☐palms ☐feet☐chest
☐Fever (how high) _____
☐Low grade fever (for how long)_____
☐Alternating Hot and Cold
(noticable temperature swings)

**General:**
☐Weight gain
☐Weight loss
☐Edema
☐Excess thirst
☐Lack of thirst
☐Hair loss
Crave: ☐sweet ☐salty ☐sour ☐spicy foods

**Sleep**
☐Restful
☐Dream-disturbed
☐Nightmares
☐Insomnia: ☐Difficult falling asleep ☐staying asleep
How many hours do you sleep each night:
_____

**Digestion/Gastrointestinal**
☐Belching ☐Gas ☐Bad breath ☐Bloating
☐Nausea ☐Vomitting
☐Diarrhea
☐Loose stools
☐Constipation
☐Undigested food in stool
☐Heart burn ☐Ulcers ☐Indigestion
☐Excess hunger
☐Low appetite ☐No appetite
☐Abdominal pain (when is it worse: ☐After eating ☐Before eating)
☐Rectal Pain ☐Hemorroids
☐Rectal Bleeding: ☐Red ☐Brown ☐Black
☐Mucus in stool
How often do you have a bowel movement:
_____
Stool is: ☐Dry ☐Hard ☐Loose ☐Pebble-like ☐Urgent ☐Watery ☐Other_____

**Head & Neck**
Headaches (where)_____
How often: _____
Cause: _____
☐Dizziness ☐Vertigo
☐Blurred vision ☐Eye pain ☐Floaters
☐Memory loss
☐Poor coordination
☐Seizures
☐Tingling ☐Numbess ☐Tremors (where)
_____

**Sweating**
☐Sweat easily without much activity
☐Hardly ever sweat
☐Night sweat
☐Profuse sweating
☐Sweating of hands and feet

**Ear/Nose/Throat/Mouth**
☐Sinus congestion ☐Runny nose☐Sneezing
☐Frequent colds ☐Sore throat ☐Infections
☐Nose bleeding
☐Ringing in the ears: (sound) ☐Low ☐High
☐Blocked ear ☐Ear pain
☐Loss of hearing
☐Bleeding Gums
☐Grinding teeth

**Chest/Respiration**
☐Shortness of Breath ☐Wheezing
☐Dry cough: ☐Day ☐Night ☐Persistant
☐Productive cough: (phlegm) ☐Thin ☐Thick
Color:_____
☐Chest pain ☐Ribside pain
☐Palpitations

**Urination**
☐Frequent urination: ☐Day ☐Night
☐Burning urination ☐Blood in the urine
☐Difficult urination ☐Dribbling
☐Urgent ☐Incontinence
☐Frequent urinary tract infections

**Emotions**
☐Nervous ☐Depressed ☐Anxious
☐Easily angered ☐Easily irritated
☐Moody ☐Manic
☐Crying easily
☐Fearful ☐Grieving

**Lifestyle**
Do you:
☐Smoke ☐Drink coffee ☐Tea(cups/day): _____
☐Drink alcohol:(glass/wk_____
☐Exercise(type/frequency):
_____

**Female Health**
Date of last menstrual period_____
Menses lasts _____days
Duration of cycle_____days
Do you menstruate regulary: ☐Yes ☐No
Color: ☐Pale red ☐Bright red ☐Dark ☐Brown
Consistancy: ☐Thick ☐Watery
Clotting: ☐Yes ☐No
☐Cramps
(better with) ☐Heat ☐Exercise ☐Rest
☐Breast tenderness
☐Acne ☐Mood changes ☐Food cravings
☐Bearing down sensation
☐Low Back pain
☐Spotting between periods
☐Menopause
☐Hot flashes
☐Vaginal dryness
Libido: ☐Low ☐High