Full Circle Wellness, LLC

Acupuncture & Herbal Medicine

Rachael Rose, Dipl.OM, MSOM, LAc
*Denver, Co 80211 * (303)480-0080*

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone Contact: _____ Work Phone:_____

E-Mail: _____ Occupation: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Referred by: _____

Have you ever had acupuncture before? Y or N

Allergies (chemical, environmental, food, drugs, etc.):_____

Emergency Contact/ Relationship: _____ Phone: _____

Reason for visit today:_____

Food Intake **Soda (12 oz.) per day**_____ **Coffee/tea per day**_____ **Alcohol per day**_____

Breakfast Dinner

Lunch Snacks

Medication/Vitamins/Supplements/Herbs

Surgeries/ Trauma

Exercise

Days per week Length of workout Types of Activity

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

☐Diabetes _____ ☐Seizures _____ ☐Heart Disease ____ ☐Stroke ____
☐High Blood Pressure____ ☐Allergies _____ ☐Cancer ____ ☐Asthma ____
☐Other_____

Personal History Please check any conditions or symptoms you have had in the last year

☐Arthritis ☐Liver/Gall Bladder Disease ☐Stroke ☐Heart Disease
☐High/Low Blood Pressure ☐Hypo/Hyperglycemia ☐Kidney Disease ☐Elevated Cholesterol
☐Cancer ☐Diabetes ☐Herpes ☐Diverticulitis/IBS
☐Ulcer ☐Seizures ☐Hepatitis ☐Raynaud's Disease

☐Chronic Fatigue ☐Anemia ☐Thyroid Imbalance ☐Respiratory Allergies
☐Alcoholism ☐Lyme disease ☐Chronic Pain Condition ☐Impotence
☐Gastritis/Pancreatitis ☐Asthma ☐Infertility ☐Emphysema

General

☐Poor Appetite ☐Insomnia ☐Fatigue ☐Chills/Fever
☐Night Sweats ☐Sweats Easily ☐Tremors ☐Muscle weakness/fatigue
☐Cravings ☐Poor Balance ☐Change in appetite ☐Bleed/Bruise easily
☐Crave hot or cold drinks ☐Weight loss/gain ☐Peculiar tastes/smells ☐Fungal Infection
☐Skin Problems ☐Rashes ☐Itching ☐Warts
☐Eczema/Psoriasis ☐Loss of hair ☐Recent moles ☐Weak or ridged nail

Cardiovascular

☐Chest pain or pressure ☐Blood clot History ☐Irregular heart beat ☐Fainting/Dizziness
☐High blood pressure ☐Edema ☐Excessive sweating ☐Cold hands/feet
☐Low blood pressure

Head, Eyes, Ears, Nose and Throat

☐Dizziness/Vertigo ☐Difficulty swallowing ☐Migraines/Headache ☐Frequent sore throats/colds
☐Vision Changes ☐Difficulty breathing ☐Spots in front of eyes ☐Dental problems
☐Eye issues ☐Ear aches ☐Grinding teeth/TMJ ☐Sores on lips/tongue
☐Sinus problems ☐Poor hearing/ringing ☐Cough/Wheezing ☐Facial pain

Gastrointestinal * Genito-Urinary * Gynecological/Reproductive

☐Nausea ☐Vomiting ☐Diarrhea ☐Abdominal pain/cramps
☐Gas ☐Bad breath ☐Constipation ☐Hemorrhoids
☐Changes in appetite ☐Heartburn/GERD ☐Rectal pain/itching ☐IBS/Crohn's Disease

☐Bloating/Edema
☐Urination issue/changes ☐Kidney stones ☐Frequent UTI's ☐Prostate issue
☐Libido Change ☐Sores on genitals ☐ Food Allergies/Intolerance ☐Pain in testicles

☐Irregular menstruation ☐Ovarian cysts ☐Age of first menses_____
☐Painful menstruation ☐Endometriosis ☐Date of last menses_____
☐PMS ☐Uterine Fibroids ☐Date of last PAP/Pelvic_____
☐Yeast infection ☐Fibrocystic breast tissue ☐Number of pregnancies_____
☐Infertility ☐Polycystic Ovarian Disease ☐Number of births_____
Do you practice birth control? _____ ☐Difficult/Painful intercourse ☐Menopause/year_____

Musculoskeletal

☐Neck pain ☐Shoulder pain ☐Hand/wrist pain ☐Carpal Tunnel
☐Knee pain ☐Sprains/Strains ☐Sciatica ☐Foot/ankle pain
☐Hip pain ☐Muscle pain ☐Muscle weakness ☐Tendonitis
☐Back pain ☐Elbow pain ☐Scalp Tension

Neuropsychological

☐Seizures ☐History of substance abuse ☐Vertigo/Dizziness ☐Depression
☐Lack of coordination ☐Memory poor ☐Head Injury/Concussion ☐Bipolar disorder
☐Anxiety ☐Irritability ☐Seasonal Affective Disorder

Are you in or have you been in therapy? ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No