Avicenna Acupuncture
www.avicennadenver.com

3411.W.38th.Ave
Denver, CO 80211
Phone: 303 803 0675

ALL PATIENT'S INFORMATION WILL REMAIN CONFIDENTIAL

Name _____ Date _____
Home Address _____
City _____ State _____ Zip _____
Phone _____ Email _____
Occupation _____ Work Phone _____
Emergency Contact: Name _____ Phone _____
Who should we thank for referring you to our office? _____
Date of Birth _____ Sex Male Height _____ Weight _____
Marital Status _____ Number of Children _____
Your primary care physician –name and phone _____

Please indicate any illness you or a blood relative (grandparent, parent, sibling) have had:

	You	Your relative	Approx. Date
Cancer	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
Rheumatic Fever	☐	☐	
Infectious Diseases	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
Seizures	☐	☐	
Emotional Disorders	☐	☐	
Tuberculosis	☐	☐	

List any medications and supplements you are currently taking:

Medicine	Dosage	Prescribed by	Dates

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Patient's Name: _____

Please indicate frequency of the following:

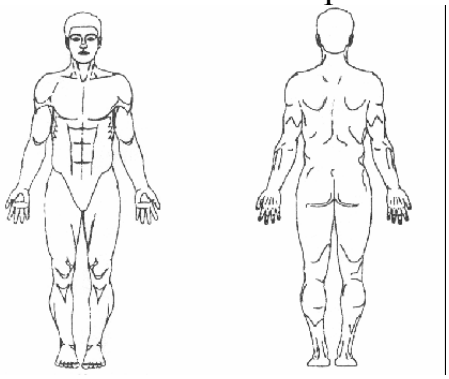
	Yes	No	How Much
Coffee	☐	☐	
Water intake	☐	☐	
Alcohol	☐	☐	
Exercise	☐	☐	

	Yes	No	How much
Tobacco	☐	☐	
Drugs	☐	☐	
Soda Pop	☐	☐	
Sugar	☐	☐	

What are the main problems for which you are seeking treatment?

_____
_____
_____
_____

Please mark the area of pain:



What other forms of treatment have you sought?

_____
_____

List any other health concerns that you have:

_____
_____
_____
_____

Do you have any known allergies?

_____
_____
_____

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Patient's Name: _____

List any accidents, surgeries or hospitalizations (please include dates):

_____
_____
_____
_____

How do you feel about the following areas of your life:

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Diet	☐	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	☐	
Self	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	

Symptom Survey
The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
NO MARK = never experience CHECK MARK (√) = experience

☐ sudden weight loss
☐ lack of appetite
☐ excessive appetite
☐ loose stool or diarrhea
☐ digestive problems, indigestion
☐ nausea, vomiting
☐ belching, burping
☐ heartburn, reflux
☐ insomnia
☐ nightmares
☐ heart palpitations
☐ restlessness
☐ cold hands and feet
☐ abdominal pain
☐ chest pain
☐ back pain

☐ recent use of antibiotics
☐ eye problems
☐ gall stones
☐ soft and brittle nails
☐ difficulty in making decisions
☐ spasms or twitching muscles
☐ knee problems
☐ hearing impairment
☐ ear ringing
☐ kidney stones
☐ decreased sex drive
☐ hair loss
☐ urinary problem
☐ fatigue
☐ edema
☐ easily bruised

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- ☐ headaches
- ☐ pain or coldness in genital area
- ☐ cough
- ☐ shortness of breath
- ☐ decreased sense of smell
- ☐ nasal problems
- ☐ skin problems
- ☐ constipation
- ☐ hemorrhoids
- ☐ .blood in the stools

- ☐ tendency to catch colds
- ☐ asthma /short breath
- ☐ intolerance to weather
- ☐ dizziness
- ☐ tendency to faint easily
- ☐ high cholesterol
- ☐ HPV
- ☐ HIV
- ☐ Chlamydia