Larkin Acupuncture

383 Rhode Island Street, Ste. 201, San Francisco, CA 94103 P 415-754-3874 www.larkinacupuncture.com

PATIENT INFORMATION

Date	First Name	Last Name	Middle Initial

Gender	Date of Birth	Age	Height	Weight	Eye Color	

Street Address	City	State	Zip

Phone (mobile)	Phone (home)	Email

Employment Status: check all that apply ☐ Unemployed ☐ Retired ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student	Employer

Occupation	Emergency Contact	Relationship	Phone

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Other:_____

Confidentiality: Your patient records and information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.

PHYSICIAN INFORMATION

Primary Care Physician	Phone

Street Address (or name of clinic/hospital)	City	State	Zip

INSURANCE INFORMATION (if applicable)

Insurance Company	Policy Holder Name	Relationship to Patient

Policy #/ ID #	Group #

Insurance Company Address	Phone

Note on Insurance: Full payment is due at the time of service. If youVhave insurance that covers acupuncture, we will be happy to submit the bill on your behalf. You ar required to pay any co-payment, deductible, and non-covered charges at time of service.

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE

1.	Date Began
2.	Date Began
3.	Date Began

Are you recovering from a cold or flu? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Have you received a Diagnosis for any of the above conditions/complaints? ☐ Yes ☐ No
If Yes, from Whom_____

What type of therapies have you tried for these problems or to improve your health over-all?
☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic
☐ acupuncture ☐ conventional drugs other_____

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams.

Medication	Purpose	How Long	Dosage	How Often	Last Dose

MAJOR HOSPITALIZATIONS, SURGERIES, ETC Please list all procedures and complications (if any)

Year	Surgery, Illness, Injury	Outcome

RECENT LAB TESTS, X-RAYS, MRI'S ETC.(please bring copies if possible)

Procedure	Purpose	Results

Mark the level of stress you experience daily: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Identify the major causes of stress: (e.g. relationship, work, legal problems, finances, illness) _____

Doyou experience daily any of the following symptoms daily:

☐ Debilitating Fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation
☐ Depression	☐ Panic Attacks	☐ Nausea	☐ Incontinence
☐ Disinterest in Sex	☐ Headaches	☐ Vomiting	☐ Low grade fever
☐ Disinterest in Eating	☐ Dizziness	☐ Diarrhea	☐ Chronic Pain
☐ Pain/Inflammation	☐ Bleeding	☐ Discharge	☐ Itching/Rash

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____

_____

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ☐+ ☐–

PAP ☐+ ☐–

Form of birth control _____

# of children _____

# of pregnancies _____

☐ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

Health Habits

☐ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

☐ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

☐ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

☐ Water: #glasses/d_____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk - #days/wk _____
- ☐ Run, jog, other aerobic - #days/wk

_____

- ☐ Weight lift - #days/wk_____
- ☐ Stretch - #days/wk_____
- ☐ Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

☐ Skip meals - which ones _____

_____

- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

BODY COMPOSITION

- ☐ Loose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more-focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

LIFE ENRICHMENT

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

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