WAILUKU COMMUNITY ACUPUNCTURE

33 CENTRAL AVENUE, WAILUKU, HAWAII 96793 808-868-6052

Welcome to WCA! To help provide you with the best possible care, please fill out this form as accurately as possible. All the information will be kept confidential in your patient file.

Name: | Birth Date:

Address:

City: State: Zip:

Gender you identify with: F M

Email (appt & specials notification):

Home Phone: | Occupation:

Work Phone: | EMERGENCY CONTACT NAME:

Cell Phone: | TELEPHONE:

Are you being treated elsewhere? Y N

For what complaint?

Personal Physician's Name:

Please list any prescription drugs or herbs you are currently taking:

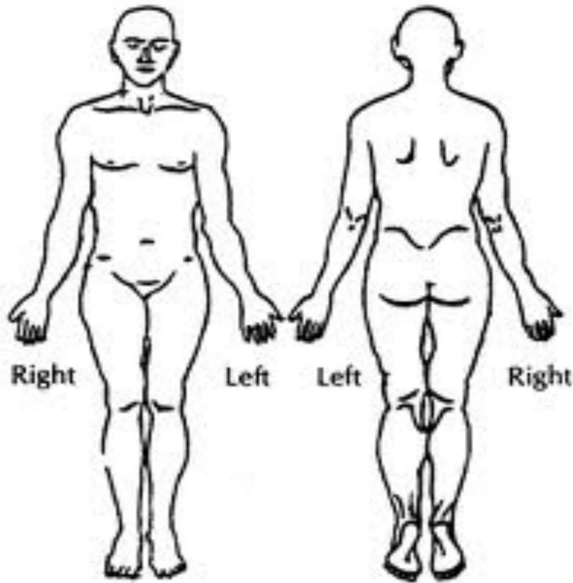
MEDICAL HISTORY: Please check all that are now or have been a part of your personal health history.

	CURRENT	PAST		CURRENT	PAST
Arthritis	☐	☐	Digestive - IBS/Crohn's	☐	☐
Allergies (specify)	☐	☐	Epilepsy	☐	☐
			Headaches/Migraine	☐	☐
Anemia	☐	☐	Heart Disease	☐	☐
Asthma	☐	☐	Hepatitis (circle) - A B C	☐	☐
Bleeding Tendency	☐	☐	HIV/AIDS	☐	☐
Blood Pressure - Hi Lo	☐	☐	Insomnia	☐	☐
Bronchitis/Emphysema	☐	☐	Depression	☐	☐
Cancer (specify)	☐	☐	Anxiety	☐	☐
			Bipolar	☐	☐
Chronic Fatigue	☐	☐	Thyroid Hypo	☐	☐
Diabetes (Type _______)	☐	☐	(Circle) Hyper	☐	☐

WHAT IS YOUR MAJOR HEALTH CONCERN TODAY? Please describe what brings you in today, and any other relevant information not mentioned above.

DO YOU USE:	Tobacco	☐	Alcohol	☐	Drugs	☐
DO YOU:	Exercise	☐	Meditate	☐	Vitamin Supl	☐

PAIN: Please circle any areas of pain or injury:



DESCRIPTION OF PAIN:

☐ SUDDEN	☐ GRADUAL
☐ NEW	☐ OLD
☐ ACUTE	☐ CHRONIC
☐ CONSTANT	☐ INTERMITTENT
☐ SHARP	☐ DULL
☐ TINGLING	☐ BURNING
☐ NUMBNESS	☐ SPASM/TREMOR
☐ RADIATES	

FROM ____________ TO _____________

PAIN LEVEL: Please circle your pain level.

REVIEW OF BODY FUNCTIONS: Please circle those that apply at this time.

MOOD:	Normal	Sad	Angry	Happy	Stressed		
ENERGY:	Normal	Low	Excessive	Low after eating			
SLEEP:	Normal _____	hrs/nite	Feel rested after sleep		Feel tired after sleep		
DRINK PREFERENCE:		Cold	Warm/Hot	Not thirsty			
APPETITE:	Normal	Increased	Decreased	Ravenous	No appetite		
DIET:	I eat it all	Vegetarian	Special Diet:	______________________________			
DIGESTION:	Gas	Hiccups	Belching	Acid Reflux	Bad Breath	Nausea	Fullness
	Vomiting	Fullness	Bloating				
BOWELS:	_____ x/day	Formed	Loose	Constipated	Diarrhea		
URINATION:	Normal	Dark Yellow	Bloody	Burning	Cloudy	At Night? ______ x/nite	

WOMEN: Please fill in the blanks & circle those that apply.

Last menses:	____________	Normal	Irregular	How many days: ___________		
Menopause:	Hot Flashes	Night Sweats				
Amount:	Normal	Heavy	Scanty	Clots		
Color:	Pale	Purple/Black	Bright Red	Brown	Dark Red	
Pain:	Before	During	After	Stabbing	Dull	PMS
History:	PID	STD	Preg ______	Vag Infections	Cysts	Endometriosis

MEN: Please circle those that apply.

Erectile Dysfunction	Premature Ejaculation	Impotence	Seminal Emission
Low Back Pain	Difficult Urination	Burning pain when urinating	

EVERYONE: Please circle those that apply.

SEX DRIVE: Normal Low Increased

MISCELLANEOUS

Is there anything else you'd like to tell me? ______________________________

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____

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SIGNATURE: ______________________________ **DATE:** ______________

Patient or Parent/Guardian if under 18