EQUILIBRIUM HEALTH

Eric Schmiedecke, MAOM L.Ac.
2161 Hendersonville Rd Ste. D, Arden NC 28704
828-333-1413 | info@equilibriumhealthavl.com

New Patient Information

Name _____ Today's Date _____

Street Address _____ Apt. _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date _____/_____/_____ Age _____ Gender _____

Occupation _____ Employer _____

Referred by _____

Current medical/health practitioner(s): _____

Emergency Contact:

Name _____ Phone _____

Street Address _____ Apt. _____

City _____ State _____ Zip _____

Fees:

It is our policy that you pay the entire session fee at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Cancellation Policy:

If you need to change or cancel your appointment please do so with a minimum of 24 hours notice by calling 828-333-1413 or emailing info@equilibriumhealthavl.com. Failure to do so will result in being charged the equivalent of 50% of the rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

Privacy Policy:

☐ **I have been given a copy of, and fully understand, the privacy policy.**

Signature:_____ **Date:** _____/_____/_____

(continued onto next pages)

Have you had acupuncture before? _____ If so, for what reason? _____

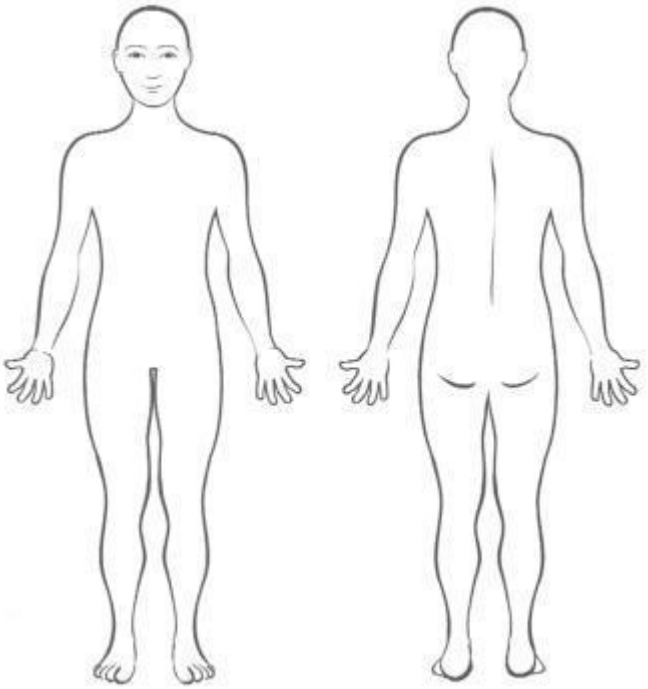
_____

Main issue(s) you are seeking treatment for: _____

_____

Diagnosis from a medical professional (if applicable): _____

Please mark any areas of pain or discomfort:



Health History

Please check any symptoms that you have experienced in the past or currently experience:

General	**past**	**current**		**past**	**current**
sweating easily during the day	□	□	fatigue	□	□
night sweating	□	□	fevers	□	□
bleed or bruise easily	□	□	chills	□	□
change in appetite	□	□	weight loss/gain	□	□
dizziness/vertigo	□	□	poor sleep	□	□

Skin & Hair	**past**	**current**		**past**	**current**
rashes/hives	□	□	psoriasis	□	□
eczema	□	□	loss of hair	□	□
acne	□	□			

Head, Ears, Eyes, Nose & Throat	**past**	**current**		**past**	**current**
earaches/pressure in the ears	□	□	headaches/migraines	□	□
ringing in the ears	□	□	sinus pressure	□	□
hearing loss	□	□	nose bleeds	□	□
eye floaters	□	□	itchy eyes	□	□
teeth/jaw clenching	□	□	blurry vision	□	□

Cardiovascular/Circulator	**past**	**current**		**past**	**current**
chest pain	□	□	swelling/edema	□	□
fainting	□	□	high blood pressure	□	□
lightheadedness	□	□	low blood pressure	□	□
cold hands & feet	□	□	cardiac pacemaker	□	□

Respiratory	**past**	**current**		**past**	**current**
pain on inhaling	□	□	sneezing	□	□
chest tightness	□	□	seasonal/other allergies	□	□
cough	□	□	phlegm production	□	□
asthma	□	□			

Genito-Urinary	**past**	**current**		**past**	**current**
difficulty urinating	□	□	urgent/frequent urination	□	□
blood in urine	□	□	sores on genitals	□	□
pain upon urination	□	□	genital pain	□	□

Neurological/Psychological	**past**	**current**		**past**	**current**
anxiety	□	□	poor memory	□	□
depression	□	□	quick temper	□	□
loss of balance/coordination	□	□	easily susceptible to stress	□	□
areas of numbness/paralysis	□	□			

Digestive	**past**	**current**		**past**	**current**
heartburn	□	□	gas	□	□
belching	□	□	diarrhea	□	□
bloating	□	□	constipation	□	□
nausea	□	□	abdominal pain/cramps	□	□
vomiting	□	□	mucus in stool	□	□
chronic bad breath	□	□	blood in stool	□	□

sores on lips/tongue	□	□	hemorrhoids	□	□

For Women Only:	**past**	**current**		**past**	**current**
irregular periods	□	□	breast pain	□	□
painful periods	□	□	vaginal discharge	□	□
bleeding between periods	□	□	vaginal sores	□	□
period clots	□	□	hot flashes	□	□
menstrual cramping	□	□	night sweating	□	□

Pregnant (yes / no / unsure) when was your last period? _____

age of first menses _____ duration of typical period _____ duration of typical cycle_____

date of last PAP _____ # of miscarriages _____ # of abortions _____

# of pregnancies _____ # of live births (+ years) _____

Have you been through menopause? _____ Age? _____

Have you ever taken birth control pills? _____When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

For Men Only:	**past**	**current**		**past**	**current**
erectile dysfunction/impotence	□	□	ejaculatory pain	□	□
varicocele	□	□	BPH	□	□

Lifestyle

Current medications/herbs/supplements:

_____

_____

_____

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

Current exercise routine:

_____

Do you use tobacco?_____ If so, how often? _____ Are you interested in quitting? Y / N

Do you drink alcohol?_____ If so, how many drinks/week? _____

Are you currently taking any other pain or over-the-counter medications? _____

If yes, list name and amounts per day:

_____

_____

Allergies (medications/foods/chemicals/etc.):

_____

_____

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer	Hepatitis	Diabetes
High blood pressure	Epilepsy	Heart Attack
Stroke	Ulcer Disease	Liver Disease
Colon Polyps	Thyroid (Hypo / Hyper)	Other _____

Please list any major surgeries/hospitalizations and approximate dates:

_____

_____

_____

Family Medical History

□ Cancer □ Seizures □ High blood pressure □ Stroke □ Diabetes

□ Heart Attack □ Hepatitis □ Asthma □ Other _____

What types of classes or educational workshops would you be interested in here at Equilibrium Health?

List some topics that might interest you: _____

_____

_____

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.