ground luminosity
Eastern Wellness Center

Confidential Patient Information Sheet

Legal Name _____ Today's Date _____
Preferred Name _____ Date of birth _____
Address _____City_____State ____ Zip Code _____
Cell phone _____ Email _____
Gender: □Male □Female □Transgender M to F □Transgender F to M
How did you hear about us: _____
Have you had acupuncture before? □Yes □No
Emergency contact: _____
Emergency contact phone number: _____ Relationship to You: _____
Relationship Status: □ Single □ Married □ Domestic Partner □ Divorced □Widowed
Primary Care Doctor: _____ Last seen: _____

Reason for your visit today: _____
Are you being treated for this condition by anyone else: ☐ Yes ☐ No
If Yes, who? _____ Phone: _____
Has this condition been diagnosed by a MD? ☐ Yes, Diagnosis: : _____ ☐ No

Daily amount used within the past 3 months: Tobacco: ☐ Yes ☐ No Amount: _____
Alcohol: ☐ Yes ☐ No Amount: _____
Recreational Drugs: ☐ Yes ☐ No Amount: _____
Coffee: ☐ Yes ☐ No Amount: _____
Do you feel you are at or near your ideal weight? ☐ Yes ☐ No
Do you feel you have enough energy? ☐ Yes ☐ No
Are you vegetarian or vegan? ☐ Yes ☐ No
Food cravings:_____
Best time of day: _____ Worst time of day:_____
Hours of sleep / night:_____ Do you feel rested after a night's sleep? ☐ Yes ☐ No
What kind of physical exercise do you do regularly? _____
Your general health as a child: ☐ Excellent ☐ Good ☐ Average ☐ Poor
Father Overall Health: ☐ Good ☐ Poor Age _____ Cause of death_____
Mother Overall Health: ☐ Good ☐ Poor Age _____ Cause of death_____

MEDICATIONS or SUPPLEMENTS:
Drug Name: Reason for Taking/Dosage:

_____
_____
_____
_____

PAYMENT, CANCELLATION, and STATUS OF HEALTH HISTORY

The information on pages 1-3 is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. Card, Cash or check are accepted forms of payment. I also understand and accept that I am expected to notify Ground Luminosity **at least 24 hours prior to any cancellations** or changes to my appointment times and that if I do not do so I may be charged for the appointment.

Signed: _____ Date: _____
Parent / Guardian (if the patient is under 18): _____

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Cardiovascular:
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:
- ☐ Mild Depression
- ☐ Clinical Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety
- ☐ Alzheimer's
- ☐ Dementia

Energy & Immunity:
- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Tuberculosis
- ☐ Shortness of Breath

Musculo-Skeletal:
- ☐ Neck /Shoulder Pain
- ☐ Muscle Spasms
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

Eye, Ear, Nose & Throat:
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems

Genito-Urinary Tract:
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence

Neurological
- ☐ Vertigo / Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy

Gastrointestinal:
- ☐ Stomach Ulcers
- ☐ GERD or Acid Reflux
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Bloating / Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Blood in Stool

Endocrine:
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes (Type I or II)
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

Other:
- ☐ Cancer (Type): _____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Cold Hand / Feet

Liver Conditions:
- ☐ Hepatitis

Reproductive:
- ☐ Impotence
- ☐ Vasectomy
- ☐ Prostate problems
- ☐ Testicular pain
- ☐ Painful intercourse
- ☐ Infertility
- ☐ Vaginal Discharge
- ☐ PMS
- ☐ Clotting
- ☐ Irregular cycles
- ☐ Scanty flow
- ☐ Heavy flow
- ☐ Spotting

Average # Days between menstrual cycles: _____
Average # Days of menstrual flow: _____
Pregnancies: _____
Births: _____
Miscarriages: _____