Coastal Wellness Health
Acupuncture & Naturopathy
520 Ocean Street, South Portland, ME 04106

Please fill out the following information to the best of your knowledge, as completely as possible.

***GENERAL INFORMATION**

Today's Date: ____/____/_____ **Title**: Mr. / Mrs. / Ms. / Dr. / Prof. **Sex**: Male / Female / Unspecified

First Name: _____ **Middle Name**: _____ **Last Name**: _____

Nickname: _____ **Date of Birth**: ____/____/_____ **SS#** (optional) _____-____-_____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Primary Phone: _____**Secondary Phone**: _____

E-Mail Address: _____ **Referred By**: _____

Emergency Contact Name: _____ **Phone #:** _____

Employment Status: Employed / Full-Time Student / Part-Time Student / Other / Retired /Self-Employed

Type of Work Performed: _____ **Marital Status**: Single / Married / Other

Though we are a cash-based practice and payment is due at the time of service, we are able to print off SuperBills for your reimbursement if our services are covered by your health care insurance provider. **Insurance Company**: _____

Race: (circle one)

White	Black/African American Asian	Hispanic	American Indian/Alaskan Native
Asian	Indian	Chinese	Filipino
Japanese	Korean	Vietnamese	Native Hawaiian/Pacific Island
Samoan	Guamanian or Chamorro	Other	I choose not to specify.

Multi-Racial: Yes / No / Unknown

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Choose not to specify.

Preferred Language: (circle one)

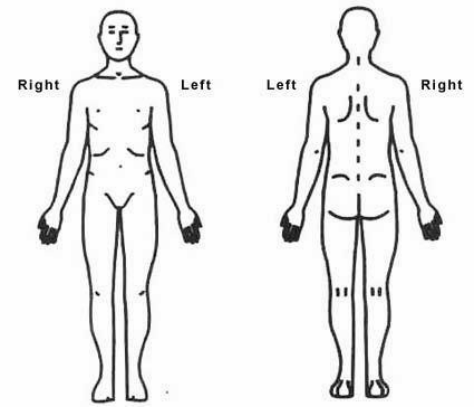
English	Spanish	Armenian	Chinese	French	German
Tagalog	Vietnamese	Italian	Korean	Russian	Polish
Arabic	Portuguese	Japanese	Hindi	Greek	French Creole
Persian	Urdu	Gujarati	American Sign Language		I choose not to specify

Verification Question: (choose one question by circling it, then give the answer to the question – *must be 6 letters or longer*)

What is the name of your favorite pet?	In what city were you born?
What high school did you attend?	What is your favorite movie?
What is your mother's maiden name?	On what street did you grow up?
What was the make of your first car?	When is your anniversary?

Answer to the verification question chosen above: _____
_____

Reason for Today's Visit: _____



(Please use the diagram to mark areas that are bothering you.)

Severity: (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Have You Experienced This Previously? Yes / No

Symptoms Began: **Date** ____/____/_____ **Or Age:** _____

Is it: Job-Related / Auto Accident / Injury / Fall / Other

Have you seen anyone else for this? _____

How does this affect your daily life? _____

What are your goals/expectations from care: _____

Have you ever seen a Chiropractor / Massage Therapist / Naturopathic Doctor / Acupuncturist **?**

Other health concerns you would like to discuss: _____

CURRENT HISTORY

***Current Medications** (including start date, frequency and dosage if known)

1._____ 4._____

2._____ 5._____

3._____ 6._____

Current Supplements: _____

***Allergies/Sensitivities (including Medications)**: _____

***Known Health Problems**: _____

Family History of Health Problems: _____

Have you broken any bones? Yes / No **If yes, which one(s) and when**? _____

***Have you had any x-rays or MRIs of your spine taken in the last year**? Yes / No _____

Have you ever had any accidents, falls, traumas or motor vehicle accidents? Yes / No If yes, please explain: _____

Have you ever been admitted to the emergency room or hospital? Yes / No _____

Have you ever had surgery? Yes / No **If yes, describe and give the date**: _____

Date of Last Physical : ___/____/_____ **Females Only – Date of Last Period**: ___/____/_____

LIFESTYLE AND HABITS

Do you use any of the following: Alcohol / Recreational Drugs / Pain Relievers / Artificial Sweeteners

Do you drink coffee, soda, or caffeinated beverages? Yes / No If yes, how many per day? _____

***Do you smoke or use tobacco**? Current Smoker / Former Smoker / Never Been a Smoker _____

How many hours of sleep do you get each night? _____ **Is it restful sleep**? Yes / No

Do you exercise regularly? Yes / No **If yes, what activities and how often**?_____

How many ounces of water do you drink each day? _____

How would you rank your dietary choices and habits on a scale of 1-10, 10 being the best? _____

Please circle the symptoms you are currently experiencing or have had serious issues with in the past:

GENERAL:

Changes in Appetite	Poor Appetite	Cravings	Strong Thirst
Thyroid Issues	Weight Loss	Weight Gain	Easy to Bleed or Bruise
Poor Balance	Fevers/Chills	Heavy Sweating	Shaking/Tremors/Tics
Sudden Energy Drops	Poor Sleep/Fatigue	Never Sweating	Night Sweats
*Diabetes (Type:___, HgA1C:_____)	Puffiness or Swelling	Weakness	Lumps or Tumors

MUSCULOSKELETAL:

Muscle Spasms/Cramping	Muscle Weakness	Muscle Achiness	Numbness or Tingling
Intervertebral Disc Issues	Arthritis	Osteoporosis	Scoliosis
Low Back Pain	Middle Back Pain	Neck Pain	Hip/Leg/Knee Pain
Shoulder/Arm Pain	Ankle/Foot Pain	Hand/Wrist Pain	Facial Pain
Sensitivity to Touch/Pressure	Pain with Activity	Weak/Stiff Joints	Pain with Weather Changes

CARDIAC & CIRCULATION:

*High Blood Pressure	Low Blood Pressure	Anemia	Clotting Disorder/Blood Clots
Cold Hands or Feet	Swelling of Hands	Swelling of Feet	Fainting
Phlebitis	Irregular Heartbeat	Palpitations	Lightheadedness
Chest Pain	Heart Attack(s)	Stroke(s)	Coronary Artery Disease

HEAD, EENT:

Dizziness	Blurry Vision	Spots in Vision/Floaters	Cataracts
Eye Strain/Pain	Night Blindness	Vision Changes	Glasses/Contact Lenses
Problems with Smell	Nose Bleeds	Sinus Problems	Lip or Tongue Sores
Recurrent Sore/Scratchy	Throat Problems with Taste	Toothache	Voice Changes
TMJ/Jaw Pain	Headaches	Migraines	Concussions
Poor Hearing	Ear Aches	Hearing Loss	Ear Ringing

SKIN & HAIR:

New or Abnormal Moles	Rashes/Hives	Skin Ulcers	Itching/Dryness
Eczema/Psoriasis	Pimples/Acne	Dandruff	Hair Loss/Thinning

NEUROPSYCHOLOGICAL:

Trouble Concentrating	Seizures/Epilepsy	Lack of Coordination	Poor Memory
Irritability/Mood Swings	Anxiety/Depression	Stress	Personality Changes

RESPIRATORY:

Cough	Pneumonia	Asthma	Bronchitis
Coughing Up Blood	Painful Breathing	Difficulty Breathing	Easily Winded

GASTROINTESTINAL:

Indigestion/Hearturn	Nausea	Vomiting	Belching
Bad Breath	Intestinal Gas	Bloating	Abdominal Pain/Cramping
Diarrhea	Constipation	Chronic Laxative Use	Hemorrhoids
Blood in Stools	Ulcers	Rectal Pain	Gallbladder Stones

UROLOGY:

Unable to Hold Urine/Incontinence	Painful Urination	Cloudy Urine	Blood in Urine
Decrease in Urine Flow	Frequent Urination	Urgency to Urinate	Frequent Night Urination
Pain in Groin Area	Kidney Stones	Sexually Transmitted Diseases	

(FEMALES ONLY)

Age of Menses: _____ years old	Duration of Menses:____days	# of Pregnancies: _____	# of Births: _____
Irregular Periods	Painful Periods	Spotting	Clots
Vaginal Discharge Changes	Yeast Infections/Vaginosis	Breast Lumps	Tender Breasts
PMS Symptoms	Fertility Problems	Menopausal – Peri/Post	Age of Menopause:____ years

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***CLINIC USE ONLY**:
HEIGHT: _____ inches **WEIGHT**: _____lbs **BLOOD PRESSURE**: _____/_____mmHg

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