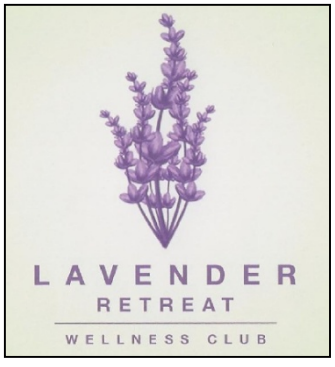


# Welcome to Lavender Retreat Wellness Club

1236 Pennsylvania Ave SE, Washington DC, 20003

## Acupuncture

All written records are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client's legal guardian — unless legally required by local, state or federal subpoena, summons, or other court order.

**"All Patients have to eat a small snack an hour before the treatment"**

Patient's Full Name: _____
SS#:_____-_____-_____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____ lbs
Sex: □ Male □ Female
Address:_____
City: _____State: _____ Zip: _____
Home Phone:(_____)_____Occupation:_____
Cell Phone: (_____)_____Work Phone: (_____)_____
Marital Status: □ Married □ Single □ Divorced □ Widowed
□ Partnered Number of Children:
E-mail Address: _____Driver's License Number: _____

List the main health problems for which you are seeking treatment:
1._____
Date of onset of symptom (s): _____
Severity of Symptoms 1-10 (1 mind/ 10 severe): _____
2._____
Date of onset of symptom (s): _____
Severity of Symptoms 1-10 (1 mind/ 10 severe): _____
3._____
Date of onset of symptom (s): _____
Severity of Symptoms 1-10 (1 mind/ 10 severe): _____

What other forms of treatment have you sought?
_____
_____

**What are your goals of treatment?**
_____
_____

**List all past Hospitalizations, Surgeries or Accidents (car accident, fall etc, include Date):** (if extensive, provide list)

_____
_____
_____

**Allergies, Food Sensitivities:**

_____

**Prescription drugs you are currently taking:** (if more than 4 provide list)

Drug Name: _____ Dosage: _____ For What?_____
Drug Name: _____ Dosage: _____ For What? _____
Drug Name: _____ Dosage: _____ For What? _____
Drug Name: _____ Dosage: _____ For What?_____

**Vitamins, Supplements, Over-the-Counter Medication you are currently taking:** (if more than 4 provide list)

Name: _____ Dosage: _____ For What?_____
Name: _____ Dosage: _____ For What?_____
Name: _____ Dosage: _____ For What?_____
Name: _____ Dosage: _____ For What?_____

_____

**Check the Box if any of the following statements is true:**

□ I have known allergies □ I am taking Coumadin/Warfarin □ History of Seizures or Seizure like activity
□ I have a pacemaker □ I am taking Lithium □ History of Head Trauma

FAMILY MEDICAL HISTORY

(Check the following conditions that have occurred in your blood relatives-grandparents, parents or siblings)

□ Allergies (list) □ Alcoholism □ Depression □ High Blood Pressure □ Tuberculosis □ Arteriosclerosis □ Cancer (type) □ Diabetes □ Seizures □ Obesity □ Asthma _____ □ Heart Diseases □ Stroke

**YOUR PAST MEDICAL HISTORY**

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

□ AIDS/HIV □ Cancer: _____ □ Measles □ Seizures □ Herpes (Type: _____) □ Alcoholism
□ Chicken Pox □ Multiple Sclerosis □ Stroke □ High Blood Pressure □ Allergies
□ Diabetes (Type: _____) □ Mumps □ Thyroid Disorders □ Venereal disease □ Appendicitis □ Emphysema □ Pacemaker □ Tuberculosis □ Rheumatic Fever □ Arteriosclerosis □ Gout □ Pleurisy
□ Typhoid Fever □ Scarlet Fever □ Asthma □ Heart Disease □ Pneumonia □ Ulcers □ Epilepsy □ Birth Trauma □ Hepatitis (Type: _____) □ Psychological Disorder □ Whooping Cough □ Goiter

Other significant Past Medical problems/medications:

_____

**PERSONAL LIFESTYLE HABITS**

Cigarettes (packs) _____ Coffee/Tea (cups per day) _____
Alcohol (drinks per week) _____ Recreational drugs: _____
Food cravings: _____ Daily Water intake (cups/day) _____
Dairy Diet that you might eat on a typical day?

• Breakfast:

_____

• Lunch:

_____

• Dinner:

_____

• Snacks:

_____

Exercise: _____How often?_____

**What non-work activities do you Enjoy doing?** (reading, hiking, TV, meditation, music, etc.)

_____

**Current Life Stresses:**

_____

**SLEEP BEHAVIOR**

What time do you go to bed at night: _____What time do you wake in the morning: _____
Do you fall asleep easily? □ Yes □ No if no, how long does it take you to fall asleep? _____
Do you stay asleep throughout the night? □ Yes □ No if no, how often do you wake throughout the night?
Do you wake rested? □ Yes □ No / Do you have vivid dreaming? □ Yes □ No / Sweat at night? □ Yes □ No
Do you wake to urinate in the middle of the night? □ Yes □ No
if yes, how often? _____

**OVERALL TEMPERATURE**

(Check all the following that apply to you.)
□ Cold Hands □ Sweaty Hands □ Usually feel Hot □ Sweat Easily □ Hot flashes any time
□ Cold Feet □ Sweaty Feet □ Usually feel Cold □ Afternoon Flushes □ Heat/Warmth in Face

**MEDICAL REVIEW OF SYSTEMS**

Please Fill this out Carefully. **One Check** = Symptom you have experienced **Two Checks** = Frequently occurring symptom

**GENERAL SYMPTOMS**

□ Poor appetite □ Large appetite □ Being overweight □ Strongly like cold drinks □ Strongly like hot drinks □ Recent weight Loss/Gain □ Fatigue □ Excessive sleeping □ Difficulty sleeping □ Lack of strength □ Bodily heaviness □ Easily catch colds □ Vague Flu-like symptoms □ Excessively thirsty □ Poor circulation □ Shortness of breath □ Fever □ Chills □ Vertigo or dizziness □ Bleed or bruise easily □ Peculiar taste in mouth □ Other: _____

**RESPIRATORY**

□ Difficulty breathing when lying down □ Shortness of breath □ Tight chest □ Asthma/wheezing
□ Difficult inhalation? exhalation? □ Cough Wet or Dry? _____ Thick or Thin? _____
Color of phlegm _____ □ Coughing up blood □ Pneumonia

**CARDIOVASCULAR**

□ High blood pressure □ Blood clots □ Low blood pressure □ Fainting □ Chest pain □ Difficulty breathing
□ Tachycardia □ Heart palpitations □ Irregular heartbeat □ Ankle swelling/edema

**PSYCHOLOGICAL**

□ Depression □ Anxiety □ Irritability □ Easily stressed □ Tendency to become Obsessive
□ Seeing a therapist

**GASTROINTESTINAL**

□ Nausea □ Vomiting □ Acid reflux □ Gassy □ Abdominal bloating □ Abdominal pain □ Bad breath □ Diarrhea □ Constipation □ Black stools □ Blood in stools □ Mucous in stools □ Hemorrhoids
□ Itchy or burning anus □ Intestinal pain or cramping □ Rectal pain □ Colitis/Diverticulitis □ Laxative use
What kind? _____ # Daily Bowel Movements _____

**MUSCULOSKELETAL**

□ Neck/Shoulder pain □ Muscle cramps or pain □ Upper back pain □ Low back pain □ Joint pain or stiffness □ Rib side pain □ Leg pain □ Radiating pain

**GENITOURINARY**

□ Pain on urination □ Frequent urination □ Urgent urination □ Blood in urine □ Unable to hold urine
□ Incomplete urination □ Wake to urinate □ Bed wetting □ Excessive Libido □ Low Libido □ Kidney Stone
□ Impotence □ Premature Ejaculation □ Nocturnal emission □ Pain with Intercourse

**MALES**

□ Inability to ejaculate or orgasm □ Scrotal pain □ Abnormal penis discharge □ Retention of urine
□ Post Void dribbling □ BPH, Prostatitis Other: _____

**HEAD, EYES, EARS, NOSE & THROAT**

□ Headaches □ Migraines □ Head injury □ Neck pain or stiffness □ Facial pain □ Glasses (What age: _____)
□ Eye strain □ Eye pain □ Red eyes □ Itchy eyes □ Eyes Sensitive to light □ Poor vision □ Blurred vision
□ See spots/shadows □ Double vision □ Glaucoma □ Cataracts □ Teeth problems □ Grinding teeth
□ TMJ □ Gum problems □ Sores on lips or tongue □ Dry mouth □ Excessive Saliva□ Excessive phlegm
Color: _____ □ Sinus problems □ Recurrent sore throat □ Lumps in throat □ Enlarged Thyroid
□ Nosebleeds □ Ringing in ears (High or Low?) □ Poor hearing □ Earaches

**NEUROLOGICAL**

□ Dizziness □ Drowsiness □ Muscle spasms or tremors □ Poor memory □ "Tics" □ Numbness
□ Convulsions/Seizures □ Slurred speech □ Speech problems (other) □ Weakness in muscles

**SKIN, HAIR**

□ Dry hair or Skin □ Itchy skin or Scalp □ Hair loss □ Eczema or Psoriasis □ Recurrent fungal infections
□ Changing moles □ Increased perspiration

**GYNECOLOGY**

Are you currently pregnant? □ Yes □ No
Age of first menses: _____ Date of last menstrual period: _____

Duration of flow _____ Blood clots: □ Yes □ No if yes, what color are they? _____
Length of cycle (i.e. 28 days) _____
Color of Menstrual blood: □ Pale Red □ Bright Red □ Red □ Dark Red □ Brown
Texture of menstrual blood: □ Thick □ Thin □ Watery □ Normal
Amount of menstrual blood: □ Light flow □ Heavy flow □ Spotting □ Normal

Pain: □ Yes □ No if yes when? (before, during or after menses)
_____
Is the Pain: □ Sharp □ Cramping □ Bloating □ Burning □ Bearing down sensation
Irregular periods(describe):_____
PMS (irritability, breast tenderness etc, please describe):
_____
Current method of contraception: _____ Past method of contraception:
_____
Number of pregnancies: _____ Number of live births: _____
Number of miscarriages: _____ Number of abortions: _____
Any premature births: _____
Breast (lumps, cysts, tenderness, etc.):
_____
Urinary tract infections: □ Yes □ No How frequent?
_____
Vaginal discharge (describe color):
_____
Pain/itching of genitalia:
_____

Date of last Pap smear: _____ Pap smear: □ Normal / □ Abnormal _____
Have you been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts
□ PID □ Interstitial Cystitis □ Other: _____

Other Symptoms related to Menses:
□ Swollen Breasts □ Nausea □ Poor appetite □ Vaginal dryness □ Headache □ Diarrhea □ Constipation
□ Mood Swings □ Ravenous appetite □ Hot flashes □ Night sweats □ Increased libido □ Decreased libido
□ Insomnia
Menopause (date of onset): _____ Symptoms:
_____
Any bleeding since Menopause?
_____

Are you currently on Hormone Replacement Therapy (HRT)? □ Yes □ No if yes, Dose: _____
How long have you been on HRT? _____ Any side effects? _____
Mammogram: _____ Bone Density Scan: _____
Other:
_____
_____
_____
_____