Sunlite
Acupuncture and Wellness

PATIENT INFORMATION

Patient Name _____ **Date:** _____

Address _____

City _____ **State** _____ **Zip Code** _____ **Sex M F**

DOB ___/___/___ **Age** _____ **SS#** _____ **Married Single Divorced**

Employer _____ **Occupation** _____

Employer Address _____

Employer Phone Number (___) _____

Email _____

Would you like to subscribe to our Monthly Newsletter? Yes No

How did you find us? Dr. _____ **/ Patient** _____ **/ Online / Insurance**

PHONE NUMBERS

Home Phone (___) _____ **Cell Phone (___)** _____

Emergency Contact Name _____ **Relationship to Patient** _____

Home Phone (___) _____ **Cell Phone (___)** _____

INSURANCE INFORMATION

Policy Holder's Name _____ **DOB** ___/___/___

Relationship to Patient _____

Insurance Company _____ **ID/Policy #** _____

Medications _____

_____

_____

Vitamins, Herbs, Minerals _____

_____

_____

Allergies _____

_____

SYMPTOMS

Please circle any of the following symptoms you have been experiencing.

Eyes, Ears, Head and Neck

Glaucoma
Tearing/Dryness
Impaired Hearing
Ear Ringing
Headaches/Migraines
Sinus Problems
Frequent Sore Throats
TMJ/Jaw Problems

Emotional

Mood Swings
Anxiety
Depression
Panic Attacks
Major Trauma
Nervousness
Poor memory
Psychiatric Care

Muscle, Joints & Bones

Muscle Cramping
Symptoms
Swollen Joints
Arthritis/Joint Pain
Herniated Disk
Tendinitis
Repetitive Strain
Rheumatism Menopausal

Gastrointestinal

Ulcers
Changes in Appetite
Nausea/Vomiting
Epigastric Pain
Passing Gas
Heartburn
Belching
Gall Bladder Disease
Liver Disease
Hepatitis B/C
Abdominal Pain

Energy and Immunity

Aids/HIV
Chronic Infections
Chronic Fatigue Syndrome

Female Reproductive

Pain During Intercourse
Breast Lumps/Tenderness
Nipple Discharge
Menopausal Symptoms
Irregular Cycles
Heavy Flow
Clotting
Difficulty Conceiving
Painful Periods
Bleeding Between Cycles

Cardiovascular

Heart Disease
Chest Pain
Swelling of Ankles
High Blood Pressure
Palpitations/Fluttering

Respiratory

Shortness of Breath
Frequent Common Colds
Difficulty Breathing
Emphysema
Persistent Cough
Asthma
Tuberculosis

Endocrine

Feeling Hot/Cold
Night Sweats
Diabetes Mellitus
Hypothyroid
Hyperthyroid

Urino-Genital

Kidney Disease
Painful Urination
Frequent UTI
Frequent Urination
Kidney Stones
Impaired Urination
Blood In Urine
Frequent Urination at Night

Neurological

Vertigo/Dizziness
Paralysis
Parkinson's Disease
Nerve Pain/Damage
Seizures/Epilepsy
Numbness/Tingling
Loss of Balance

Skin and Hair

Psoriasis
Skin Rashes
Itching
Acne
Eczema
Hives
Hair Loss

HEALTH HISTORY

Reason for visit _____

When did your symptoms appear? _____

Activities or movements that is painful to perform

Sitting Standing Walking Bending Lying down

What treatments have you received for your condition?

Medication / Surgery / Physical Therapy / Chiropractic Services / Other _____

On the picture to your right, please indicate all areas of discomfort or pain by marking them with an X.