Yampa Valley Acupuncture & Chinese Herbs, LLC

100 Park Avenue, Suite 210, Steamboat Springs, CO 80487 • 970-819-6738

Welcome to Yampa Valley Acupuncture & Chinese Herbs. Please complete this form to help me provide you with the best possible care. All information will remain confidential.

Name:	Date:
Date of birth:	Gender: F M
Mailing Address Street:	
City: State:	Zip:
Physical Address Street:	
City: State:	Zip:
Mobile Phone #:	Email address:
Occupation:	Employer:
Emergency Contact Name: Phone #: Address:	Relationship:
Physician's Name: Phone #:	
Have you received acupuncture or Chinese herbs in the past? Y N	
How did you hear about this clinic?	
Reason for today's visit:	
Are you being treated elsewhere for this condition? Y N	
If yes, by whom?	

Please list any prescription medications you are taking:
Please list any herbs or supplements you are taking:
Please list any medications you are allergic to:

Please check all boxes that are now or have been part of your health history:

- ☐ Addiction (drugs/alcohol)
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bleeding
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Digestive Disorder
- ☐ Depression/Anxiety
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV Positive
- ☐ Hypoglycemia
- ☐ Injuries
- ☐ Insomnia
- ☐ Intestinal Parasites
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Surgery
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other:

_____
_____
_____
_____

Please list any surgeries you have had, including date:
Please list any serious accidents you have had, including date:
Have you had any serious illness in the past? If yes, describe:

Family Health History

Please check any conditions that have occurred in any blood relatives:

☐ Alcoholism	☐ Heart Disease	☐ Seizures
☐ Allergies	☐ High Blood Pressure	☐ Obesity
☐ Cancer	☐ High Cholesterol	☐ Stroke
☐ Diabetes	☐ Kidney Disease	☐ Other:

Father	☐ Living, Age:____	☐ Deceased, Age:____	Cause:_____
Mother	☐ Living, Age:____	☐ Deceased, Age:____	Cause:_____
Spouse	☐ Living, Age:____	☐ Deceased, Age:____	Cause:_____
Siblings	#:_____	Health Status:_____	
Children	#:_____	Health Status:_____	

Please describe your typical daily diet: Breakfast: Lunch: Dinner: Snacks:
Please describe your exercise routine:
Are you currently under any unusual stress?
Which of the following are part of your lifestyle: ☐ Tobacco ☐ Recreational Drugs ☐ Supplements ☐ Coffee ☐ Birth Control Pills ☐ Other: ☐ Alcohol ☐ Meditation/Relaxation

Women Only

Age of first menstruation:
Age at menopause:
Date of first day of last menstrual period:
Number of days of bleeding:
Length of monthly cycle:
Are your periods: ☐ Heavy ☐ Light ☐ Normal flow
Are your periods irregular? ☐ Y ☐ N If yes, describe:

Are your periods painful? ☐ Y ☐ N What relieves pain?

What is the color of blood?
☐ Dark Red ☐ Light Red ☐ Purple ☐ Brown ☐ Red

What is the consistency of the blood?
☐ Thick ☐ Watery ☐ Clotted ☐ Normal

Do you experience spotting? ☐ Y ☐ N If yes, when?

Once your period starts, does it stop & then start again? ☐ Y ☐ N

Do you experience PMS? ☐ Y ☐ N If yes, please check the appropriate boxes:

☐ Painful, swollen breasts	☐ Cramps	☐ Constipation
☐ Irritability	☐ Nausea	☐ Other:
☐ Depression, crying	☐ Bloating	
☐ Food cravings	☐ Diarrhea	

Have you had any gynecological surgeries or problems? ☐ Y ☐ N
If yes, please describe:

Pregnancies
Total #:_____
# of children:_____ Ages:_____
# of miscarriages:_____
Complications:

Men Only

Please check any of the following symptoms you experience:

- ☐ Reduced libido
- ☐ Excessive libido
- ☐ Premature ejaculation
- ☐ Impotence
- ☐ Genital discharge
- ☐ Frequent urination
- ☐ Other:

System Review

Please put one check mark by a symptom that you occasionally experience, two checks for those that occur often, and three checks by any symptom that is a major concern to you.

Head & Face
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory
- ☐ Other:

Eyes
- ☐ Blurry vision
- ☐ Red, itchy
- ☐ Floaters
- ☐ Pain
- ☐ Poor eyesight
- ☐ Other:

Ears
- ☐ Ringing
- ☐ Excessive ear wax
- ☐ Earaches
- ☐ Hearing difficulty
- ☐ Other:

Nose
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Bleeding
- ☐ Loss of smell
- ☐ Allergies
- ☐ Other:

Mouth
- ☐ Bleeding gums
- ☐ Tooth decay
- ☐ Jaw tension
- ☐ Tongue problems
- ☐ Unusual tastes
- ☐ Loss of taste
- ☐ Other:

Throat
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Other:

Respiratory
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling
- ☐ Frequent lung infections
- ☐ Chest congestion
- ☐ Cough
- ☐ Asthma
- ☐ Other:

Cardiovascular
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Tightness in chest
- ☐ Chest pain
- ☐ Low blood pressure
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Cold limbs, hands, feet
- ☐ Hot palms or soles
- ☐ Other:

Gastrointestinal
- ☐ Excessive hunger
- ☐ Low appetite
- ☐ Excessive thirst
- ☐ No thirst
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Gas or bloating
- ☐ Other:

Skin
☐ Rashes
☐ Acne
☐ Dryness
☐ Night sweats
☐ Excessive sweating
☐ Rarely sweat
☐ Moles that change
☐ Other:

Urination
☐ Frequent
☐ Burning
☐ Difficult
☐ Painful
☐ Incontinence
☐ Blood in urine
☐ Other:

Neurological
☐ Seizures
☐ Numbness
☐ Tingling
☐ Nerve pain
☐ Lack of coordination
☐ Other:

Psychiatric
☐ Anxiety
☐ Depression
☐ Mania
☐ Paranoia
☐ Other:

Sleep
☐ Insomnia
☐ Wake frequently
☐ Vivid dreams
☐ Always sleepy
☐ Other:

Energy Level
☐ High
☐ Low
☐ Normal
☐ Other:

Musculoskeletal
☐ Joint pain
☐ Weak muscles
☐ Muscle cramps
☐ Stiff muscles
☐ Osteoporosis
☐ Other:

Pain
Please describe:
_____
_____
_____
_____
_____

I authorize treatment by Kelley McDaneld, a licensed acupuncturist at Yampa Valley Acupuncture & Chinese Herbs, LLC. All info on this form is correct to the best of my knowledge. I understand that I am responsible for all fees to Yampa Valley Acupuncture & Chinese Herbs on the day services are rendered.

Patient signature_____ Date_____

Consent to treat a minor: I hereby authorize Yampa Valley Acupuncture & Chinese Herbs to administer treatment to my child, _____
(child's name)

Parent/Legal Guardian signature_____
Date_____