Tolley Sink

Licensed Acupuncturist & Herbalist

Patient Information:

Name*: _____

Date: _____

Age: _____ Date of Birth: _____ Social Security #:

_____

Address:

_____

_____Primary Phone: _____ ☐ Home ☐ Work

☐ Cell

OK to leave a message? ☐ Yes ☐ No

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

OK to leave a message? ☐ Yes ☐ No

Email: _____

Occupation: _____ Student? ☐

Yes ☐ No

Referred By: _____

* If patient is a child, please list parent's name here:

_____

Emergency Contact Information

Name: _____

Phone: _____

Primary Physician's Name: _____

Phone: _____ Fax:

_____

What is your main complaint or complaints? If more than one please number in order of importance.

When did it start and what precipitated it?

What makes it better? (Rest, movement, heat, cold, eating, support)

What makes it worse? (stress, fatigue, heat, cold, damp weather)

Where in your body do you experience pain or tension?

What makes the pain better? (heat, ice, movement, rest)

What makes the pain worse? (movement, inactivity, stress, cold, heat, damp weather)

Please read carefully and circle if you have any of the following:

Heavy or weak feeling arms and or legs

Skin rashes or acne
Swelling (where?)
Foggy head
Easily chilled or cold, easily warm or uncomfortably hot
Abnormal sweating, inability to sweat, strong smelling sweat
Bone deformities
Lower back, knee or ankle pain that is worse with fatigue
Urinary symptoms (retention, dribbling, hesitation, burning, concentrated, strong smelling, cloudy)
Difficulties with anger or irritability
Symptoms that change relative to your menstrual cycle
Weak fingernails, ridges in your fingernails
Eye floaters, decreased night vision
Rib side or breast pain, swelling, distention
Yucky taste in the mouth, difficulty digesting fats

Cough, shortness of breath, wheezing, sneezing, sinusitis, rhinitis

Poor appetite, nausea, vomiting, flatulence, irregular bowel movements, abdominal sounds, abdominal fullness, abdominal distention, easily uncomfortably full after eating, regurgitation, hiccough, very thirsty for cold drinks, thirsty but don't like to drink

Insomnia, heart palpitations, poor memory, poor concentration, emotional difficulties

Please list any surgeries or hospitalizations and their date:

Please list any other trauma (physical or emotional)

Please list any allergies (chemical, environmental, foods, drugs, seasonal)

Please share your exercise routine if you have one (days per week, length of workout, type of activity)

How is your sleep?

<u>Eating habits</u>

Do you eat the following:

Dairy products (milk, yogurt, cheese, etc)?

Red meat (beef, venison, lamb, pork)?

Fish or fowl (tuna, salmon, chicken, turkey)?

Eggs?

Commercially canned food?

Fruit?

Vegetables and legumes?

Whole grains (rice, millet, oats)?

Soy products (tofu, soy milk, tempeh)?

Please mark how often you consume these items:

Sugar

Soda/soft drinks

Pastries/ donuts

Cookies/ cake

Ice cream

Coffee

Alcohol
Recreational drugs

Please write what a typical daily diet looks like for you including breakfast, lunch, dinner, snacks, and liquids)

Please list all vitamins and supplements you are taking, the reason, and the dosage:

Please list all medications you are taking, the reason and the dosage:

Gynecological/Reproductive

Please circle if you have any of the following:

Difficult/painful intercourse Vaginal dryness Vaginal sores

Vaginal discharge Infertility Irregular menstruation

Ovarian cysts Endometriosis Uterine fibroids Breast distention/ soreness

Fibrocystic breast tissue Polycystic Ovarian Disease PMS

Painful menstruation

How long is your average cycle from one period to another?

How many days do you menstruate?

Is your flow light, normal or heavy?

Date of last menses

Number of pregnancies

Number of live births

Number of miscarriages

Number of abortions

Do you practice birth control? What type? How long?

Family History

Please list any ailments that have affected your relatives. Please list your relatives current age, or age they were at death.

Relative	Age	Ailment
Mother		
Father		
Brother		
Sister		
Grandmother		
Grandfather		
Aunt		
Uncle		

Do you have a spouse or partner?

If yes, please list their name, age, occupation and any other significant information

Do you have any children?

If yes, please list their names, ages and any other significant information

Do you have any pets?

If yes, please list their name and type of animal

Please inform me of anything else you would like to discuss: