Medicine Wheel Dental & Wellness Center
520.743.7101
Dianne Darcy L. AC., LLC
Patient Health History

NAME			DATE OF BIRTH	
Address	City		State	Zip
Home Phone	Cell Phone	Work Phone	Email Address	
Height:	Weight:	Occupation:		
Family Physician:		Referred by:		
Emergency Contact:		Phone:		
__ Single	__Married/Partnered	__ Separated	__ Divorced	__ Widowed
__ Previously treated by acupuncture or Chinese Medicine				

What problems would you most like help with?
_____

How long have you had these problems? _____

To what extent do these problems interfere with your daily activities?
_____

Have you been diagnosed for these problems, if so what?
_____

What treatments have you received for these problems?
_____
Level of pain: 1-10 _____ Level of stress: 1-10_____
Past Medical History & Dates (P for Past, N for Presently, or give dates where appropriate):
__ Cancer/Type _____; __ Diabetes; __ High Blood Pressure; __ Heart Disease; __ Hepatitis; __ Joint Disease; __ Joint Dislocations; __ Rheumatic Fever; __ Seizures; __ Venereal Disease
Falls or Accidents _____
Surgeries_____
_____
Do you wear any electronic device?__ Y __N If yes, which one ?_____

Major life events (marriage, separation, loss of job, move, deaths) & dates :
_____
Allergies:_____
Current Medications, Dosages, Time Taken Last 2 months:
_____
_____
Supplements:
_____

DIANNE DARCY L.AC., LLC
520-481-9001

__ Prefer winter	__ Prefer hot drinks	__ Cold hands	__ Cold feet
__ Prefer summer	__ Prefer cold drinks	__ Night sweats	__ Feet feel hot
Energy: __ Good	__ Average	__ Poor	Better __ am ___ pm
__ Back pain	__ Weak/sore knees		__ Deafness/Tinnitus
Urination:	__ Painful	__ Frequent	__ Night time
__ Low sex drive	__ Joint Pain		
__ Poor concentration	__ Poor memory	__ Dizziness	__ Fearfulness
__ Constipation	__ Diarrhea	# BM/day_____	__ Gas
__ Shortness of breath	__ Excessive sweat	__ Insufficient sweat	__ Cough
__ Nasal discharge	__ Sinusitis	__ Allergies	__ Asthma
__ Skin problems	__ Grief		
__ Heavy appetite	__ Low appetite	__ Bloating	__ Abdominal pain
__ Bleeds/bruises	__ Weight gain	__ Weight Loss	__ Fatigue
__ Worry			
__ Chest pain	__ Palpitations	__ Insomnia	__ Vivid Dreaming
__ Mouth Sores	__ Anxiety		
__ Muscle Spasm/ Tension	__ Dizziness/ Vertigo/ Tremors	__ Vision/Eye Problems	_ Indigestion/heartburn
__ Frustration/ Anger/ Irritability	__ Depression		__ Headaches/Migraines
Age 1st menses____	Length cycles_____	# Days of flow _____	PMS
__ Clots	# Live births _____	# Miscarriages ____	Age menopause ____

Consent to Treat
I request and consent to acupuncture treatment which may also include moxibustion, cupping, electrical stimulation, massage, Oriental herbal medicine, and nutritional counseling. I understand that acupuncture is generally safe, but that it may have some side effects, including bruising, numbness or tingling near needling sites that may last a few days, dizziness or fainting.

Patient Signature _____ Date_____

Acknowledgement Cancellation Policy
One to one and one-half hours are set aside for your appointment. If you are unable to make your appointment, kindly notify me 24 hours in advance -- missed appointments are charged $45.

Patient Signature _____

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