WELCOME to the Acupuncture Practice of THOMAS ÖST, M.A., L.Ac.

PATIENT INFORMATION

NAME	FIRST	M.I.	LAST

I AM A PATIENT AT	☐ The Center @ 5840 5840 Ellsworth Avenue, Suite 302 Pittsburgh, PA 15232	☐ The Acupuncture Clinic in Cranberry 325 Thomson Park Drive Cranberry TWP, PA 16066

HOME ADDRESS	STREET

CITY	STATE	ZIP

EMAIL ADDRESS	

DATE OF BIRTH	MM	DD	YY	GENDER	☐ M	☐ F
MARITAL STATUS	S	M	Sep	D	W	SS #
OCCUPATION		EMPLOYER				

HOME PHONE		WORK PHONE		CELL PHONE	

EMERGENCY CONTACT	NAME	RELATIONSHIP	PHONE

SPOUSE'S NAME	
CHILD(REN)'S NAME(S) AND AGE(S)	

MEDICAL HISTORY

MAJOR COMPLAINT/HEALTH PROBLEM (Please describe your reason for this visit)	
HOW DID THE CONDITION DEVELOP?	
HOW LONG HAS THE CONDITION PERSISTED?	

TREATMENT	☐ No Treatment Received	If received, WHERE?

BY WHOM?	WHAT WAS THE DIAGNOSIS?
WHAT KINDS OF TREATMENT?	RESULTS OF TREATMENT

CURRENT HEALTH STATUS

COULD YOU BE PREGNANT?	☐ YES	☐ NO
DO YOU HAVE A PACEMAKER?	☐ YES	☐ NO
DO YOU HAVE A BLEEDING PROBLEM?	☐ YES	☐ NO
DO YOU HAVE HEPATITIS?	☐ YES	☐ NO
DO YOU HAVE HIV/AIDS?	☐ YES	☐ NO

HAVE YOU EXPERIENCED SYMPTOMS, PROBLEMS OR CHANGES IN ANY OF THE FOLLOWING?		
ALLERGIES	☐ YES	☐ NO
ARTHRITIS/GOUT	☐ YES	☐ NO
BLEEDING/BRUISING/ANEMIA	☐ YES	☐ NO
BLOOD CLOTS	☐ YES	☐ NO
BOWEL PROBLEM	☐ YES	☐ NO
CANCER	☐ YES	☐ NO
CHOLESTEROL	☐ YES	☐ NO
CIRCULATION PROBLEM	☐ YES	☐ NO
DEPRESSION	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO
ENERGY	☐ YES	☐ NO
FAINTING	☐ YES	☐ NO
FEVER/CHILLS	☐ YES	☐ NO
FREQUENT COLDS	☐ YES	☐ NO
HEADACHE/MIGRAINE	☐ YES	☐ NO
HEART PROBLEM	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO
KIDNEY DISEASE	☐ YES	☐ NO
LUNG DISEASE	☐ YES	☐ NO
LUPUS	☐ YES	☐ NO
NAUSEA	☐ YES	☐ NO
NEUROLOGICAL PROBLEM	☐ YES	☐ NO
RASHES OR MASSES	☐ YES	☐ NO
SEX LIFE	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO
SINUS PROBLEM	☐ YES	☐ NO
SKIN CHANGES	☐ YES	☐ NO
SLEEP PROBLEM	☐ YES	☐ NO
STOMACH PROBLEM	☐ YES	☐ NO
STROKE	☐ YES	☐ NO
SWEATS	☐ YES	☐ NO
THIRST	☐ YES	☐ NO
THYROID DISEASE	☐ YES	☐ NO
URINATION/BLADDER PROBLEM	☐ YES	☐ NO
VOMITING	☐ YES	☐ NO
WEIGHT CHANGES	☐ YES	☐ NO

WHICH OF THE FOLLOWING MAKES YOUR PAIN OR SYMPTOMS WORSE? (Please check all that apply)		
☐ Alcohol	☐ Heat	☐ Menstruation
☐ Bending/Twisting	☐ Inactivity	☐ Poor Sleep
☐ Bright Lights	☐ Lifting	☐ Sitting
☐ Changes in weather	☐ Loud Noises	☐ Standing
☐ Cold	☐ Lying Down	☐ Stress
☐ Exercise	☐ Meals	☐ Walking
☐ Other:		

WHICH OF THE FOLLOWING MAKES YOUR PAIN OR SYMPTOMS BETTER? (Please check all that apply)		
☐ Activity	☐ Heat	☐ Relaxation
☐ Distraction	☐ Ice	☐ Rest
☐ Exercise	☐ Prayer	☐ Warm Shower
☐ Medications:		
☐ Other:		

LIST ALLERGIES	

LIST ALL CURRENT MEDICATIONS			
NAME	STRENGTH	# PER DAY?	FOR HOW LONG?

ARE YOU CURRENTLY TAKING and/or HAVE YOU EVER TAKEN NUTRITIONAL SUPPLEMENTS/HERBS? If so, please list.

LIST ANY MAJOR SURGERIES YOU HAVE HAD	
DATE	PROBLEM/SURGERY

SIGNIFICANT TRAUMA (Auto Accidents, Falls, etc)

SIGNIFICANT ILLNESSES (Please check all that apply)		
☐ Arthritis	☐ Diabetes	☐ Rheumatism
☐ Asthma	☐ Gallstones	☐ Ruptured Appendix
☐ AIDS	☐ Heart Disease	☐ Seizures
☐ Autoimmune Disease	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ Cancer	☐ Hypertension	☐ Thyroid Disease
☐ Connective Tissue Disease	☐ Kidney Stones	☐

FAMILY HISTORY

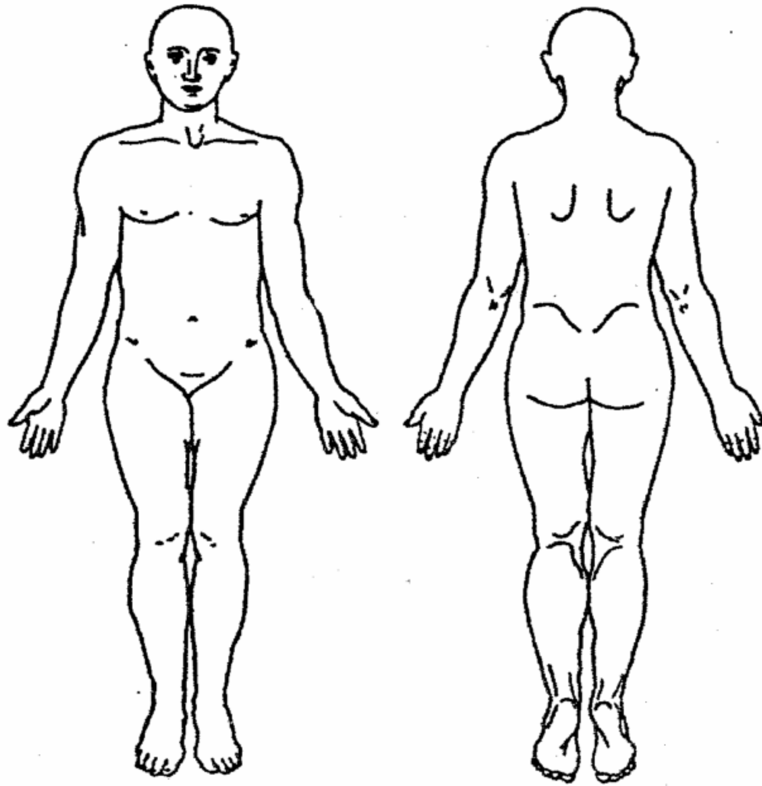
(Please check all that apply)

☐ Cancer	☐ Hypertension	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis
☐ Heart Disease	☐ Rheumatic Disease	

SOCIAL HISTORY

Do you smoke?	☐ Yes	☐ No	I would like to stop smoking	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No	I would like to stop drinking alcohol	☐ Yes	☐ No
Do you drink coffee?	☐ Yes	☐ No	Tell me about alternatives to coffee	☐ Yes	☐ No
Do you use drugs (other than prescribed or medication)?	☐ Yes	☐ No	I would like to stop using drugs	☐ Yes	☐ No
Are you living in a domestic situation where you experience physical (e.g., hitting, punching) and/or emotional/verbal/psychological (e.g., humiliation, excessive control, possessive, threatening) abuse?				☐ Yes	☐ No

PLEASE NOTE ANY QUESTIONS OR OTHER CONCERNS THAT YOU WOULD LIKE ME TO ADDRESS OR BE AWARE OF

PLEASE SHADE ALL AREAS IN WHICH YOU ARE EXPERIENCING PAIN OR OTHER SYMPTOMS			
			
SIGNATURE		DATE	