

# **Counterpoint Wellness, PLLC**

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Today's date \_\_\_\_\_

Name \_\_\_\_\_ Nickname \_\_\_\_\_

Phone (primary) \_\_\_\_\_ (secondary) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Is it ok if we communicate with you by email? Yes  No

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_ Marital/Partnership Status \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Family Physician \_\_\_\_\_ Referred By \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Have You Been Treated By Acupuncture or Oriental Medicine Before?: Yes  No

Have You Been Treated By Craniosacral Work Before?: Yes  No

**Main Problem(s)** you would like help with \_\_\_\_\_

\_\_\_\_\_

How long ago did this problem begin (be specific)? \_\_\_\_\_

\_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, etc)? \_\_\_\_\_

\_\_\_\_\_

Have you been given a diagnosis for this problem: If so, what? \_\_\_\_\_

\_\_\_\_\_

What kinds of treatment have you tried? \_\_\_\_\_

\_\_\_\_\_

**Past Medical History** (please include date): Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Hepatitis \_\_\_\_\_

High Blood Pressure \_\_\_\_\_ Heart Disease \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Thyroid Disease \_\_\_\_\_

Seizures \_\_\_\_\_ Venereal Disease \_\_\_\_\_ HIV/AIDS \_\_\_\_\_ Other \_\_\_\_\_

**Surgeries** (type of and date) \_\_\_\_\_

\_\_\_\_\_

**Significant Trauma** (auto accidents, falls, etc) \_\_\_\_\_

\_\_\_\_\_

**Significant Dental Work** (type and date) \_\_\_\_\_

**Do You Have Mesh, Metal, or Other Material Implanted In Your Body** Yes  No

Location(s) \_\_\_\_\_

**Allergies** (drugs, chemicals, foods/result) \_\_\_\_\_

**Family Medical History** (check): Diabetes  Cancer  High Blood Pressure

Heart Disease  Stroke  Seizures  Asthma  Allergies

Other  \_\_\_\_\_

**Medicines** taken within the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement

Reason for Taking It

Name of Medication/Supplement	Reason for Taking It
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Occupational Stress** (physical, chemical, psychological, etc) \_\_\_\_\_

Do you have a **regular exercise program**? Yes  No  Please Describe \_\_\_\_\_

Are you on a **restricted diet**? Yes  No  What Kind? \_\_\_\_\_

How many **cigarettes** do you smoke per day? \_\_\_\_\_

How much **coffee, tea or cola** do you drink per day? \_\_\_\_\_

How much **alcohol** do you drink per week? \_\_\_\_\_

Please describe any use of recreational drugs \_\_\_\_\_

**Please check any you have had in the last three months:**

**General**

- Poor appetite
- Fevers
- Sweat easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Sudden energy drop - what time of day? \_\_\_\_\_
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Night sweats
- Cravings
- Change in appetite
- Weight gain
- Weight loss

**Skin and Hair**

- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Recent moles
- Other hair or skin problems

**Head, Eyes, Ears, Nose, and Throat**

- Dizziness
- Glasses
- Poor vision
- Cataracts
- Ringing in ears
- Sinus problems
- Grinding teeth
- Teeth problems
- Concussions

- Eye strain
- Night blindness
- Blurry vision
- Poor hearing
- Nose bleeds
- Facial pain
- Jaw clicks
- Migraines
- Eye pain
- Color blindness
- Earaches
- Spots in front of eyes
- Recurrent sore throats
- Sores on lips or tongue
- Headaches - where and when \_\_\_\_\_
- Other head or neck problems \_\_\_\_\_

**Cardiovascular**

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Phlebitis
- Chest pain
- Fainting
- Swelling of feet
- Difficulty in breathing
- Other heart or blood vessel problems \_\_\_\_\_

**Respiratory**

- Cough
- Bronchitis
- Difficulty in breathing when lying down
- Production of phlegm what color \_\_\_\_\_
- Coughing blood
- Pneumonia

- Asthma
  - Pain with a deep breath
  - Other lung problems \_\_\_\_\_
- Approximately when was your last cold or flu?  
\_\_\_\_\_

**Gastrointestinal**

- Nausea
- Constipation
- Black stools
- Bad breath
- Abdominal pain or cramps
- Chronic laxative use
- Vomiting
- Gas
- Blood in stools
- Rectal pain
- Diarrhea
- Belching
- Indigestion
- Hemorrhoids
- Other stomach or intestinal problems \_\_\_\_\_

**Genito-urinary**

- Pain on urination
  - Urgency to urinate
  - Frequent urination
  - Unable to hold urine
  - Impotency
  - Blood in urine
  - Kidney stones
  - Sores on genitals
  - Other genital or urinary system problems \_\_\_\_\_
- Do you wake up to urinate?  
 Yes  No.  
How often?  
\_\_\_\_\_

Any particular color to your urine? \_\_\_\_\_

**Pregnancy and Gynecology**

Number of pregnancies \_\_\_\_\_  
Number of births \_\_\_\_\_  
Premature births \_\_\_\_\_  
Miscarriages \_\_\_\_\_  
Abortions \_\_\_\_\_  
Age at first menses \_\_\_\_\_  
Days between menses \_\_\_\_\_  
Duration \_\_\_\_\_  
First day of last menses \_\_\_\_\_

- Unusual character (heavy or light)
- Painful periods
- Vaginal discharge  
What color? \_\_\_\_\_
- Changes in body/psyche prior to menstruation
- Clots
- Vaginal sores
- Irregular periods
- Last Pap \_\_\_\_\_
- Breast lumps

Are you sexually active?  
\_\_\_\_\_

Do you practice birth control?

- Yes    No    N/A

What type and for how long?  
\_\_\_\_\_

**Musculoskeletal**

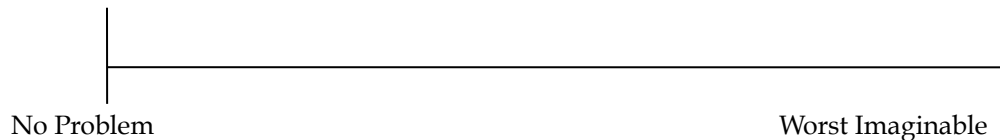
- Neck pain
- Back pain
- Hand/wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain

**Neuropsychological**

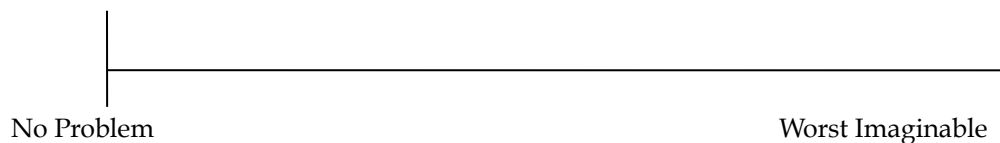
- Seizures
- Areas of numbness
- Concussion
- Bad temper
- Dizziness
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Other neurological or psychological problems

\_\_\_\_\_  
\_\_\_\_\_

**Please note the severity of your problem now:**



**Please note the severity of your problem within the last week:**



**Comments** (please mention any other problems you would like to discuss):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_