Counterpoint Wellness, PLLC

Samara White, EAMP, LMT
AC60503724; MA60461701
206.395.9796
counterpointwellness.com

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 __________________________________

Is it ok if we coordinate care with your physician if needed? Yes ☐ No ☐

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

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?
____

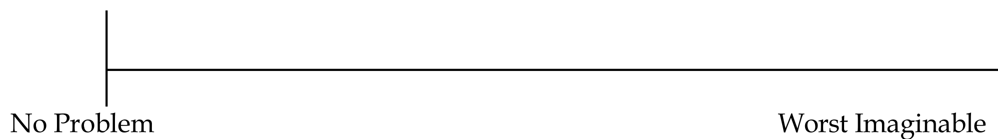
Musculoskeletal

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

Neuropsychological

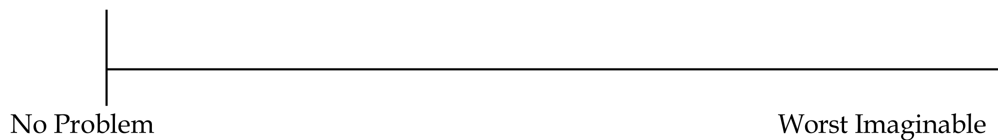
- ❑ Seizures
- ❑ Areas of numbness
- ❑ Concussion
- ❑ Bad temper
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Anxiety
- ❑ Other neurological or psychological problems
  ____
  ____

Please note the severity of your problem now:



No Problem Worst Imaginable

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



No Problem Worst Imaginable

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

____
____
____