Inner Light Wellness New Patient Form
Margaret Celli, L.Ac., NCCAOM

Name_____Address_____
_____
Phone
(H)_____(W)_____(Cell)_____
Occupation_____Employer_____
Date of Birth_____ Age_____ E-Mail_____
Emergency
Contact_____Phone_____
Medications/Vitamins_____
_____
Physician_____ Referred by_____

Primary reason for visit_____
_____
When did symptoms first appear?_____ Are they worsening?_____
What makes it better?_____
What makes it worse?_____
Other health concerns_____
Previous injuries (describe and date)_____
_____
Surgery/Hospitalizations (describe and date)_____
_____
Have you ever had acupuncture/herbs?_____Are you receiving other therapies?_____
Describe_____

MEDICAL HISTORY:

Your history:

____Heart disease	____Blood clots	____Spinal Problems
____Bleeding disorder	____Diabetes	____Osteoporosis
____Low Blood Pressure	____High Blood Pressure	____Stroke
____Hepatitis	____Alcoholism/Drug addiction	____Cancer
____HIV/AIDS	____Allergies	____Asthma
____Appendicitis	____Depression	____Pneumonia
____Serious Fever	____Seizures	____Chicken Pox
____Kidney Disease	____Thyroid Disorder	____Measles

Other:_____
_____

_____

Family History:

____Heart disease ____Blood clots ____Cancer
____Diabetes ____High Blood Pressure ____Osteoporosis
____Stroke ____Alcoholism ____Allergies
Other:_____

Stressors affecting your
life_____
_____

WOMEN:
(If you are post-menopausal, please answer the following based on menstrual history.)

Describe your typical menstruation_____
_____

____Age menses began ____Clots ____Color of menses
____Length of cycle ____Cramping ____Length of flow
____Vaginal discharge ____Vaginal odor ____Vaginal Dryness
____#Pregnancies ____#Births ____#Miscarriages
____Fibroids/Cysts ____Yeast infections ____#Abortions
____Bladder infections ____Genital herpes ____Genital warts
____Painful intercourse ____Low libido ____Sexual dysfunction
____Oral contraceptives ____HRT ____Breast lumps/tenderness
____Recent change in menses (describe)_____
_____
Any other menstrual issues?_____

MEN:

____Difficulty starting urination ____Stopping and starting urination
____Urinary dribbling ____Urgent urination
____Premature ejaculation ____Difficult to attain/maintain erection
____Genital pain ____Low libido
____Genital rash ____Genital herpes
____Enlarged prostate ____Genital warts

DIET:

____Low Appetite ____Heavy Appetite ____Coffee/Tea
____Meat ____Vegetarian ____Vegan
____Thirsty ____Prefer Hot Beverages ___Prefer Cold Beverages
____Crave Sweets ____Crave Salt

Average Daily Menu:

Breakfast	Snack	Lunch	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

For the following symptoms, please indicate your experience as follows:

1=occasionally 2=frequently

____Feeling of Heat in Chest
____Shortness of Breath
____Chest Pain
____Heart Palpitation
____Tight Chest
____Irregular Heartbeat
____Heart Attack
____Difficult to Fall Asleep
____Difficult to Stay Asleep
____Dream Disturbed Sleep
____Anxiety
____Agitation
____Restlessness
____Easily Startled
____Poor Memory
____Speech Difficulty
____Ulcers Mouth/Tongue
____Cold/Swollen Hands

____Asthma
____Allergy
____Sinus Problem
____Nosebleeds
____Sore Throat
____Dry Throat/Mouth
____Loss of Voice
____Dry Cough
____Wet Cough
____Coughing Blood
____Bronchitis
____Pneumonia
____Easily Sweat
____Absence of Sweat
____Dry Skin
____Skin Rash
____Itching

____Fatty Tumors
____Goiter
____Spider Veins
____Lumps

____Frequent Urination
____Painful Urination
____Difficult to Pass Urine
____Inability to Hold Urine
____Dark/Pale Urine
____Blood in Urine
____Nighttime Urination
____Urgent Urination
____Lack of Sex Drive
____Premature Gray
____Low Back Pain
____Knee Pain
____Kidney Stones
____Hearing Loss
____Night Sweating
____Ear Ringing (Low)
____Swollen Legs/Feet
____Cold Feet

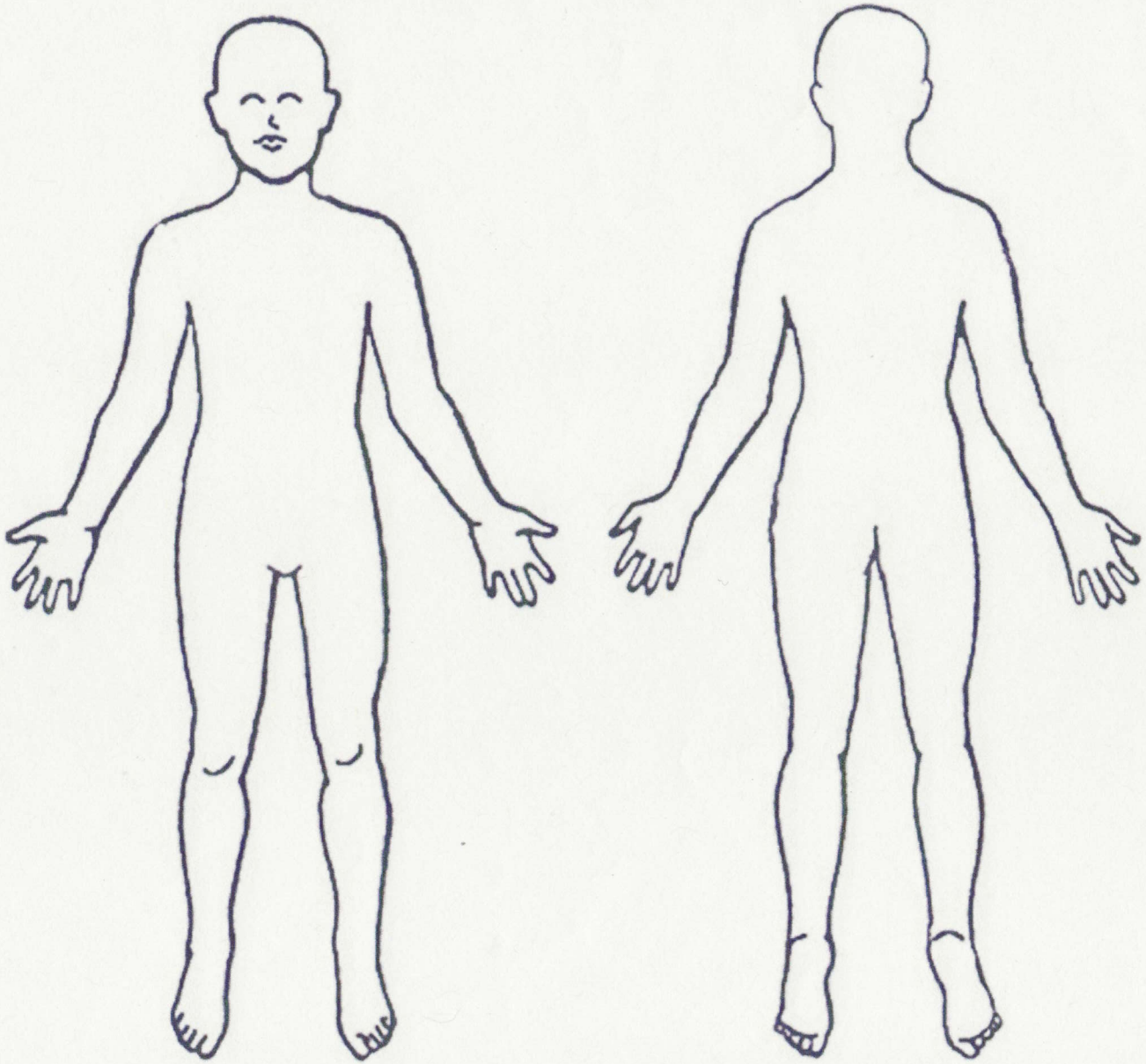
____Fatigue
____Indigestion
____Heartburn
____Bleeding Gums
____Abdominal Pain
____Constipation
____Diarrhea/Loose Stool
____Mucus in Stool
____Blood in Stools
____Dizzy if Stand Too Fast
____Nausea
____Belching
____Bloating
____Acid Regurgitation
____Thirst Excess/Little
____Easy Bruising
____Feel Heavy
____Varicose Veins
____Hemorrhoids
____Bad Breath
____Weak Muscles

____Stress
____Headaches
____Sighing
____Depression
____Lump in Throat
____Anger/Irritation
____Light Sensitivity
____Dry Eyes
___Red/Itchy Eyes
___Poor Night Vision
____Spots/Floaters
____Ridged Nails
____Numb/Tingling
____Rib Pain
____Spasms/Tics
____Ear Ringing(Hi)
____Dizziness
____TMJ-Grinding
____ Breast Pain
____Glasses

<u>Bowel Movements:</u>
Frequency_____
Color_____
Texture_____
(loose or formed)

<u>Pain?</u>
Location _____
_____

Describe _____
_____
_____
Does it radiate?_____
Rate the severity 1-10
_____
Does it interfere with daily activity?_____

<u>Headache?</u>
Describe_____
_____

Using the colored pen, please shade in areas of pain or tension.
Please include areas of radiating pain.