Acupuncture & Wellness Clinic of Ruskin 813-645-8168
207 4th St. NW Ruskin, FL 33570

Name_____
Address_____
City_____State_____Zip_____
Phone_____Work_____Cell_____
Age____Date of Birth_____Occupation_____
In case of emergency notify_____Phone#_____
Name of Primary care Physician_____
Referred by_____
Have you tried Acupuncture or Chinese Medicine before?_____
What is your main problem?_____
To what extent does this problem affect your daily activities (work, sleep, eating, etc.)
_____
How long has it been since you first noticed symptoms?_____
If you have been diagnosed for this problem by a physician, what was the diagnosis?
_____
What kinds of treatments or therapy have you tried?_____
_____

Past medical history (check all that apply)

___Allergies	___Rheumatic fever	___Cancer
___Diabetes	___Difficulty breathing	___Hepatitis
___Thyroid Disease	___High Blood Pressure	___Low Blood Pressure
___Poor Appetite	___Weight Gain	___Weight Loss
___Insomnia	___Cravings	___Strong Thirst
___Tremors	___Chills	___Poor Balance
___Dizziness	___Headaches	___Sinus Problems
___Seizures	___Irregular Heartbeat	___Asthma
___Poor Balance	___Fainting	___Night Sweats
___Bronchitis	___Nose Bleeds	___Grinding teeth
___Recent Moles	___Facial Pain	___Thyroid Problems
___Pneumonia	___Chest Pain	___Stroke
___Heart Disease	___Venereal disease	___Localized weakness
___Sudden energy drop	___Rashes	___Concussions
___Eye pain	___Earaches	___Jaw clicks
___Swelling of hands or feet	___Cough	___Blood clots
___Coughing up blood	___Birth Trauma(Prolonged labor, forceps delivery,etc)	

___Accidents or significant trauma_____
___Other significant illnesses_____
___Surgeries_____
Other relevant Medical history_____
_____
_____
_____
_____