Dr. Petra Tibshraeny
MTech Hom, DOM, AP
Tel: 727-420-7600
7241 Bryan Dairy Road
Suite B, Largo, FL 33777
E-mail: acupunctureandhomeo@gmail.com

Acupuncture & Homeopathy Clinic

Homeopathic Practitioner
Doctor of Oriental Medicine
Acupuncture Physician
License #: AP4119
Web: www.anhclinic.com

New Patient Information

Your personal and medical information is confidential. We use it to evaluate your health profile to provide you with the most effective healthcare. Please be as accurate as possible to ensure the best outcomes. Thank you.

Date: _____ /_____ / _____

Last name: _____ **First:** _____ **Middle:** _____

Date of Birth: _____ /_____ / _____ Gender: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ -_____ Email: _____

Permission to text appointment reminders: ☐ Yes ☐ No

Permission to email appointment reminders: ☐ Yes ☐ No

Permission to email newsletters: ☐ Yes ☐ No

Occupation: _____

Primary Care Physician: _____

Phone: (_____) _____ -_____ Email: _____

Emergency Contact: _____ Relation: _____

Phone: (_____) _____ -_____ Email: _____

Person responsible for payment (if not you): _____

Phone: (_____) _____ -_____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Have you ever had acupuncture?		Chinese herbal medicine?		Homeopathic treatments?	
☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

How did you hear about us? _____

Name: _____	Date of Birth: _____ /_____ / _____

Health History

Family Health History: Please check the appropriate box and explain as necessary.							
	Age (alive or dead?):	Asthma:	Diabetes:	High Blood Pressure:	Heart Disease:	Cancer:	Other:
Mother:		☐	☐	☐	☐	☐	
Father:		☐	☐	☐	☐	☐	
Sister(s):		☐	☐	☐	☐	☐	
Brother(s):		☐	☐	☐	☐	☐	
Grandparents Maternal:		☐	☐	☐	☐	☐	
Grandparents Paternal:		☐	☐	☐	☐	☐	

Personal History: Current prescription, supplements and over the counter medication.			
Medication:	Dosage:	Time on medication:	Reason:

Surgeries		Physical Traumas (e.g. falls, auto accident)	
Type:	Date:	Type:	Date:

Check if you have or had any of the following: Check "C" (CURRENT) for the past 3 months and "P" (PAST) for longer than 3 months.

C	P		C	P		C	P		C	P	
☐	☐	HIV/AIDS	☐	☐	Celiac Disease	☐	☐	Guillain-Barre	☐	☐	Mumps
☐	☐	Alzheimer's	☐	☐	Sjogren's Syn.	☐	☐	Bleeding dis.	☐	☐	Rubella
☐	☐	Osteoarthritis	☐	☐	MS	☐	☐	Birth trauma	☐	☐	Polio
☐	☐	Rheumatoid Art.	☐	☐	IBD	☐	☐	Chicken Pox	☐	☐	Whooping Cough
☐	☐	Lupus	☐	☐	Diabetes 1 / 2	☐	☐	Measles	☐	☐	Rheumatic Fever
☐	☐	Scarlet fever	☐	☐	Meningitis	☐	☐	Chr. fatigue	☐	☐	Gout

Name: _____	Date of Birth: _____ /_____ / _____

Conditions Continued:											
C	P		C	P		C	P		C	P	
☐	☐	Gallstones	☐	☐	Jaundice	☐	☐	Liver disease	☐	☐	Hepatitis (Type?)
☐	☐	High cholesterol	☐	☐	Herpes (Type?)	☐	☐	Lyme's dis.	☐	☐	Malaria
☐	☐	Mononucleosis	☐	☐	Osteopenia	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Cancer (Explain)									
☐	☐	Allergies (Explain)									

Lifestyle: Check "C" (CURRENT) for the past 3 months and "P" (PAST) for longer than 3 months.					
C	P	Specify types and frequency where necessary.	C	P	Specify types and frequency where necessary.
☐	☐	Tobacco	☐	☐	Exercise
☐	☐	Marijuana	☐	☐	Occupational hazards
☐	☐	Recreational drugs	☐	☐	Hobbies
☐	☐	Alcohol	☐	☐	High stress
☐	☐	Coffee	☐	☐	Sugar intake
☐	☐	Tea	☐	☐	Artificial sweetener
☐	☐	Soda and/or juice	☐	☐	Vegan
☐	☐	Water	☐	☐	Vegetarian
☐	☐	Energy drinks	☐	☐	Gluten free
☐	☐	Fast food	☐	☐	Other diets

General Health: Check appropriate boxes. Add notes if necessary or leave lines blank.					
☐	Poor appetite	☐	Sweat easily (where on body)	☐	Low energy in general
☐	Hearty appetite	☐	Lack of sweating	☐	High energy in general
☐	Unusually thirsty	☐	Weight loss	☐	Sudden energy drops (what time)
☐	Not thirsty in general	☐	Weight gain	☐	Are you a "night owl"
☐	Like cold beverages	☐	Chills	☐	I am a slow starter in the morning
☐	Like warm/hot beverages	☐	Fever	☐	Take naps during the day

Thermal Perception:					
☐	Cold hands or feet	☐	Feel warm at night	☐	Prefer mountains
☐	Warm hands or feet	☐	Feel cool at night	☐	Like fresh air and open windows
☐	Feel hot in face, chest, hands	☐	Prefer humidity	☐	Affected by changes in weather
☐	Easily get cold	☐	Prefer dry environment	☐	Aversion to wind/draughts
☐	Easily get hot	☐	Prefer seaside		

Name: _____	Date of Birth: _____ /_____ / _____

Sleep:			
☐	Restful sleep through the night	☐	Insomnia
☐	Poor sleep (how many hours per night)	☐	Sleepwalk
☐	Difficulty falling asleep (How long does it take?)	☐	Dream-disturbed sleep
☐	Light sleeper (easy wake from noises)	☐	Nightmares
☐	Waking up frequently (How many times/night?)	☐	Hot flashes
☐	Pain prevents me from sleeping	☐	Night sweats
☐	Wake up not feeling rested		
☐	Wake up at specific time and difficult to fall back asleep (specify time)		

Head, Eyes, Ears, Throat and Nose:					
☐	Migraine	☐	Earache	☐	Frequent hoarseness
☐	Headaches	☐	Ear discharge	☐	Swollen glands
☐	Red eyes	☐	Ringing in ears	☐	Lumps in throat
☐	Itchy eyes	☐	Meniere's disease	☐	Enlarged thyroid
☐	See spots/floaters	☐	Hearing loss	☐	Hyperthyroid
☐	Poor vision	☐	Loss of sense of smell	☐	Hypothyroid
☐	Blurred vision	☐	Nasal obstruction	☐	Decrease in taste
☐	Double vision	☐	Nasal discharge (color)	☐	Dry mouth/throat
☐	Night blindness	☐	Snoring	☐	Excessive saliva
☐	Color blindness	☐	Sinusitis	☐	Sores on lips/tongue
☐	Far or near sighted (circle)	☐	Frequent sneezing	☐	Teeth problems
☐	Glaucoma	☐	Frequent colds/flu	☐	Grinding teeth
☐	Cataracts	☐	Nosebleeds	☐	Clenching teeth
☐	Sty	☐	Excessive phlegm in throat	☐	Many cavities or root canals
☐	Eye strain/pain	☐	Recurrent sore throat	☐	TMJ
☐	Glasses/contact lenses (age)	☐	Tonsillitis	☐	Facial pain
☐	Ear infections	☐	Strep throat	☐	Gum problems

Respiratory System:					
☐	Difficult breathing when lying down			☐	Difficult to inhale
☐	Shortness of breath	☐	Asthma/Wheezing	☐	Difficult to exhale
☐	Tight chest	☐	Emphysema	☐	Cough (if productive what color?)
☐	Hay fever	☐	Bronchitis	☐	Pneumonia

Name: _____	Date of Birth: _____ /_____ / _____

Cardiovascular System:					
☐	Chest pain	☐	Arrhythmia/irregular heartbeat	☐	Dizziness
☐	Chest tightness	☐	Heart murmur	☐	Blood clots
☐	Shortness of breath	☐	Pacemaker (date)	☐	Poor circulation
☐	Heart disease (specify)	☐	Palpitations	☐	Swollen ankles
☐	High blood pressure	☐	Tachycardia/fast heart rate	☐	Swelling hands/feet
☐	Low blood pressure	☐	Varicose veins	☐	Anemia
☐	Fainting				

Gastrointestinal Tract:					
☐	Indigestion	☐	Nausea/vomiting	☐	Undigested food in stool
☐	Abdominal bloating	☐	Peculiar taste in mouth (specify)	☐	Black stool
☐	Abdominal or stomach pain	☐	Cravings (sugar, salt, sour, spicy)	☐	Hemorrhoids
☐	Heartburn/Acid reflux	☐	Constipation	☐	Rectal pain or burning
☐	Belching	☐	Diarrhea	☐	Anal fissures
☐	Hiccup	☐	Loose stool	☐	Regular laxative use
☐	Bad breath	☐	Bowel movements (frequency)	☐	Rectal prolapse
☐	Difficult swallowing	☐	Mucus in stool	☐	Frequent antibiotic use
☐	Tired after eating	☐	Blood in stool		

Hair, skin and nails:					
☐	Dry, brittle hair	☐	Dry skin	☐	Eczema
☐	Dandruff	☐	Itchy skin	☐	Psoriasis
☐	Itchy scalp	☐	Oily skin	☐	Acne
☐	Hair loss	☐	Bruise easily	☐	Vitiligo
☐	Premature grey hair	☐	Rashes	☐	Fungal infections (specify)
☐	Brittle nails	☐	Hives	☐	Warts
☐	Change in skin texture	☐	Ulceration	☐	Lipomas

Neuropsychological:					
☐	Concussion (date)	☐	Numbness/tingling	☐	Anxiety
☐	Convulsion	☐	Poor memory	☐	Panic attacks
☐	Epilepsy	☐	Poor concentration	☐	Mood swings
☐	Stroke	☐	Stuttering or stammering	☐	Worry easily
☐	Tics	☐	Irritability	☐	Stress
☐	Fainting	☐	Frustration	☐	PTSD
☐	Tremor	☐	Anger	☐	Fearful

Name: _____	Date of Birth: _____ /_____ / _____

Neuropsychological Continued:					
☐	Parkinson's disease	☐	Grief or sadness	☐	Forgetful
☐	Loss of balance	☐	Cry uncontrollably	☐	Mind not clear
☐	Vertigo	☐	Depression	☐	Difficulty expressing emotions
Musculoskeletal:					
☐	Muscle pain	☐	Neck pain	☐	Hand/Wrist pain
☐	Muscle weakness	☐	Shoulder pain	☐	Back pain
☐	Muscle spasms	☐	Tennis elbow	☐	Spinal disc problems
☐	Restless legs	☐	Golfer's elbow	☐	Hip pain
☐	Knee pain	☐	Foot/Ankle pain	☐	Tendonitis
☐	Other joint or bone problems				
Genitourinary Tract:					
☐	Urination (how many times in day)			☐	Cloudy urine
☐	Urination (how many times at night)			☐	Blood in urine
☐	Dark urine	☐	Dilute urine	☐	Burning urine
☐	Painful urination	☐	Urgent urination	☐	Urinary tract infections
☐	Scanty urine	☐	Poor bladder control	☐	Bedwetting
☐	Profuse urine	☐	Difficult urination or retention	☐	Kidney disease
☐	Frequent urination	☐	Kidney stones		
For women only:					
☐	Abnormal pap smear	☐	Scanty periods	☐	Pelvic inflammatory disease
☐	Increased libido	☐	Breast lumps/tenderness	☐	Chronic yeast infections
☐	Decreased libido	☐	Endometriosis	☐	Leucorrhea
☐	Pain with intercourse	☐	Fibroids	☐	Vaginal dryness
☐	Painful periods	☐	PCOS	☐	Sores or itching genitalia
☐	Regular periods	☐	Facial hair	☐	Venereal disease
☐	Irregular periods	☐	Difficulty conceiving	☐	Menopausal symptoms
☐	Bleeding btw periods	☐	Miscarriages	☐	Uterine prolapse
☐	Clots in menstrual blood	☐	Abortions	☐	Hysterectomy (total or partial)
☐	Heavy periods				

Name: _____	Date of Birth: _____ /_____ / _____

Women: Please provide written answers to these questions.	
Date of last pap smear?	
Are you currently pregnant or trying to become pregnant?	
Date of last period:	
Past birth control methods:	
Current birth control methods:	
Age of first period:	
Describe PMS symptoms:	
Length of period:	
How many days between period (From onset to onset)?	
Number of pregnancies:	
Number of live births:	
Ages of children:	
Age at menopause:	

For men only:					
☐	Increased libido	☐	Genital sores	☐	Low sperm count/motility/morphology
☐	Decreased libido	☐	Venereal disease	☐	Nocturnal emission
☐	Impotence	☐	Testicular lumps	☐	Premature ejaculation
☐	Genital pain, swelling or itching	☐	Varicocele	☐	Prostate problems (PSA reading)

Name: _____	Date of Birth: _____ /_____ / _____

Please list, in order of importance, your reason for visiting today:			
1. Reason for visit	**When did it start?**	**Any significant event around that time?**	**What seems to make it better and/or worse?**
How does it affect your daily life?	**Describe the pain if any?**	**Do you have a diagnosis?**	**Have you had imaging done?**
Please list, in order of importance, your reason for visiting today:			
2. Reason for visit	**When did it start?**	**Any significant event around that time?**	**What seems to make it better and/or worse?**
How does it affect your daily life?	**Describe the pain if any?**	**Do you have a diagnosis?**	**Have you had imaging done?**
Please list, in order of importance, your reason for visiting today:			
3. Reason for visit	**When did it start?**	**Any significant event around that time?**	**What seems to make it better and/or worse?**
How does it affect your daily life?	**Describe the pain if any?**	**Do you have a diagnosis?**	**Have you had imaging done?**
For Office use only:			

Name: _____	Date of Birth: _____ /_____ / _____

Indicate with an “X” areas of discomfort, pain or concerns.