Young Mountain Wellness LLC
Amy E. Young, LAc, RD, LE
41184 US-6 Avon, CO 81620
phone: 412.389.8297

Patient Information

Name _____ date _____

address _____

city _____ state _____ zip _____

home phone _____ work phone _____

cell phone _____ e-mail _____

date of birth _____ occupation _____

do you enjoy work? Y/N why/why not? _____

gender_____ age _____ weight _____ height_____

blood pressure_____ marital status_____ level of education completed _____

nicotine/alcohol/caffeine/recreational drug use: _____

how many glasses of water do you drink per day? _____

have you experienced any major traumas? Y/N explain _____

referred by _____ had acupuncture before?_____

name of primary care physician _____

emergency contact _____ phone _____

Main complaints:

what is your primary reason for seeking treatment? _____

_____

when problem began _____ have you had this in the past? _____

if so, when? _____

is your condition: [ ] getting worse [ ] staying constant [ ] coming & going

what makes it better? _____

what makes it worse? _____

what diagnosis have you been given? _____

what kinds of treatment have you tried? _____

do you have any other complaints or health issues?_____

_____

please list any medications, drugs, herbs or supplements you are taking _____

_____

_____

how would you describe your health as a child? _____

_____

please check any conditions you have now or had in the past:

[ ] allergies	[ ] cancer	[ ] heart disease	[ ] pacemaker
[ ] asthma	[ ] diabetes	[ ] hepatitis	[ ] pneumonia
[ ] alcoholism	[ ] epilepsy	[ ] HIV/AIDS	[ ] mental disorder
[ ] drug addiction	[ ] glaucoma	[ ] high fever	[ ] STD
[ ] jaundice	[ ] kidney disease	[ ] multiple sclerosis	[ ] thyroid disorder
[ ] tuberculosis	[ ] weight gain	[ ] stroke	[ ] fibromyalgia
[ ] hypertension	[ ] weight loss	[ ] ulcers	[ ] chronic fatigue

[ ] other _____

are you under the care of any other health care providers & for what conditions?

_____

_____

list any significant illnesses which you have in the past (include dates)

_____

_____

list any surgeries, significant injuries, broken bones, etc. (include dates)

_____

_____

list any allergies or sensitivities to any medications, foods, or other substances

_____

_____

what do you typically eat in a day?

_____

_____

what type of exercise do you do?

_____

_____

do you have a spiritual practice?

_____

_____

how many hours per night do you sleep?

_____

_____

is there anything else you'd like me to know about? _____

_____

_____

_____

_____

The information given on this form is accurate & correct, and I hereby consent to and authorize treatment by the practitioners at Young Mountain Wellness.

I understand that I am responsible for payment of my account, and that payment is due at the time services are rendered.

patient signature _____ date _____

consent to treat a minor child (name) _____

parent/legal guardian _____