



**Maya Crockett Acupuncture and Chinese Medicine**

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**Patient Information** (Please complete as much as you can)

Today's Date \_\_\_/\_\_\_/\_\_\_\_\_

Name (Last, First, MI) \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Sex:  Male  Female

Email: \_\_\_\_\_

Phone# Cell: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Health History**

Who is your primary physician? (doctor/or practice) \_\_\_\_\_

Please check if you're **currently** experiencing any of the following conditions;

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms  | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         |
| <input type="checkbox"/> Arm/Hand Pain       | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        |
| <input type="checkbox"/> Leg/Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |

Please check if you have **ever had** any of the following;

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> AIDS/HPV      | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Mumps                | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia             | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herniated Disk     | <input type="checkbox"/> Parkinson's          | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Anorexia      | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Herpes             | <input type="checkbox"/> Pinched Nerve        | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Appendicitis  | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Tumors/Growths     |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Polio                | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Bleeding      | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Disorders     | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Breast Lump   | <input type="checkbox"/> Gonorrhea           | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Bronchitis    | <input type="checkbox"/> Gout                | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Bulimia       |  | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Fever                |   |

**Initial Evaluation** (Please be honest and fill in as much as possible)

Main Complaints:

How long have you suffered the problem?

- 1) \_\_\_\_\_ / \_\_\_\_\_
- 2) \_\_\_\_\_ / \_\_\_\_\_
- 3) \_\_\_\_\_ / \_\_\_\_\_

Any other complains:

Would you like improvement with any of the following?

- Digestion: Reflux, gas, constipation, bloating
- Sleep: Falling asleep or staying asleep
- Sense of Well Being
- Energy

What have you tried doing to resolve this problem that **Did Not Work**?

When your problem is at its worst, how does it make you feel?

Do you know how this problem may have started?

Are you here visiting us to: (please select)

- a) Resolve my immediate problem (palliative/relief care)
- b) Try life-style program for optimized health and living (long-term corrective care)
- c) Both
- d) Other, Please explain: \_\_\_\_\_

How have you taken care of your health in the past?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Medications        | <input type="checkbox"/> Routine Physical | <input type="checkbox"/> Exercise       |
| <input type="checkbox"/> Diet and Nutrition | <input type="checkbox"/> Holistic/Natural | <input type="checkbox"/> Vitamins/Herbs |
| <input type="checkbox"/> Chiropractic       | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Massage        |
| <input type="checkbox"/> Prayer             | <input type="checkbox"/> Meditation       | <input type="checkbox"/> Other: _____   |

How did the previous methods of care work for you?

Please list any medications and dosages you're currently taking:

What and how are you afraid that this may be or will be affecting without change (i.e. job, mobility, freedom, family, marriage, sleep, finances, traveling, etc.) ?

What would be different or better without this problem?

- |  |                                 |                                       |
|--|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Diminished Stress | <input type="checkbox"/> Sleep  | <input type="checkbox"/> More Energy  |
| <input type="checkbox"/> Self Esteem       | <input type="checkbox"/> Work   | <input type="checkbox"/> Confidence   |
| <input type="checkbox"/> Outlook on life   | <input type="checkbox"/> Family | <input type="checkbox"/> Other: _____ |

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

What potential barriers do you foresee that would prevent these things from happening?

What are your strengths that will enable you to accomplish your goals?

**Please rate the following on the scale of 1-10 (10 being the most likely)**

\_\_\_\_\_ How important is it for you to resolve your health concerns

\_\_\_\_\_ Do you feel that you are coachable and would enjoy a mentor in helping you?

\_\_\_\_\_ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

\*Following are programs we have available at our facility. Please select the ones you may be interested in participating in order to help achieve your health goals.

- Acupuncture     Massage     Nutrition     Yoga     Herbs/Supplements