# *Maya Crockett Acupuncture and Chinese Medicine*

602 E Main Street Suite C Allen TX 75002: 469-795-6647: Maya@MayaCrockettAcu.com

**Patient Information** (Please complete as much as you can) Today's Date___/___/___

Name (Last, First, MI) _____ DOB: ___/____/_____

Sex: ☐Male ☐Female Email: _____

Phone# Cell: _____Work: _____Occupation:_____

Can we call you at work? ☐Yes ☐No

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;

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

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

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

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Name: _____ Date: _____

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?

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

_____

How does this problem interfere with the following areas of your life?

Work: _____
Family: _____
Hobbies: _____
Relationships: _____

When it's at its **worst**, how much OLDER does this make you feel? _____

Do you know how this problem may have started?

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Are you here visiting us to: (please circle)

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?

| | | |
|---|---|---|
| □Medications | □Routine Physical | □Exercise |
| □Diet and Nutrition | □Holistic/Natural | □Vitamins/Herbs |
| □Chiropractic | □Physical Therapy | □Massage |
| □Prayer | □Meditation | □Other: _____ |

How did the previous methods of care work for you? _____

_____

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

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Would you like to work on getting off of some or all of these medications? □Yes □No

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

_____

Are there any health conditions you are afraid this may turn into (cancer, heart disease, diabetes, depression, weight gain, increased stress, surgery, more medication, etc.)? _____

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Where do you picture yourself being in the <u>next 3-5 years</u> if this problem is not taken care of?

*__Please be specific__

_____

_____

_____

_____

What would be different or better without this problem?

| | | |
|---|---|---|
| □Diminished Stress | □Sleep | □More Energy |
| □Self Esteem | □Work | □Confidence |
| □Outlook on life | □Family | □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 circle the ones you may be interested in participating in order to help achieve your health goals.

**Acupuncture Massage Nutrition Personal Training Yoga Herbs/Supplements**