Awaken Now Acupuncture & Wellness Inc.

Dr Marina Dabcevic LAc, DAOM
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Personal Information

Patient Name:

_____

Age: _____ Birth Date: _____/_____/

_____

Gender:

_____

Address:

_____

City:

_____

State: _____

Zip:_____

Telephone (Day:)

_____

Telephone (Mobile):

_____

Email Address:

_____

Occupation:

_____

Referral Source:

_____

Who is your primary heath care provider/MD?

_____

Emergency Contact: _____Phone:

_____

Main Complaint

1. Please identify your major health concerns_____
   _____
   ___
   _____
   ___
   _____
   ___

   How long have you had this problem?
   _____

   Have you been given a diagnosis for these problems?
   _____
   _____

   What other treatments have you tried and what were the outcomes?
   _____
   _____
   ___

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Personal Medical History *(Please include your childhood history)*

Illnesses	
Surgeries	
Significant Trauma: (i.e. motor	
Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	

Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you	

General (please check all that apply)

	Poor Appetite		Weakness		Sudden Energy Drops
	Hearing Loss		Fevers		Chills
	Easy to Bleed or Bruise		Sweat Easily		Fatigue
	Strong Thirst		Poor Sleep		Tremors
	Puffiness or Swelling		Poor Balance		Weight Loss
	Night Sweats		Cravings		Weight Gain
	Changes in Appetite		Other:		

Skin & Hair

	Rashes		Itching	Dandruff
	Skin Ulcers		Eczema	Hair Loss
	Hives		Pimples	Recent Moles

Head, Eyes, Ears, Nose, and Throat

	Dizziness		Toothache	Blurry Vision
	Cataracts		Ear Ringing	Sinus Problems
	Taste/Smell Problems		Headaches	Concussions
	Eye Strain/Pain		Night Blindness	Poor Hearing
	Nose Bleeds		Facial Pain	TMJ Pain
	Migraines		Ear Aches	Spots in Front of Eyes
	Recurrent Sore Throat		Lip or Tongue Sores	Floaters

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Cardiovascular

	High Blood Pressure		Low Blood Pressure		Irregular Heartbeat
	Cold Hands or Feet		Blood Clots		Palpitations
	Swelling of Hands		Swelling of Feet		Chest Pain
	Phlebitis		Fainting		Lightheadedness

Respiratory

	Cough		Bronchitis		Difficulty Breathing
	Phlegm		Coughing Up Blood		Pneumonia
	Asthma		Painful Breathing		Easily Winded

Gastro-Intestinal

	Nausea		Constipation		Diarrhea
	Bad Breath		Ulcers		Abdominal Pain
	Chronic Laxative Use		Vomiting		Intestinal Gas
	Indigestion		Rectal Pain		Belching
	Blood in Stools		Hemorrhoids		

Urology

	Painful Urination		Urgency to Urinate		Unable to Hold
	Decrease in Urine Fl		Frequent Urination		Blood in Urine
	Cloudy Urine		Kidney Stones		Frequent Night Urination
	Pain in Groin Area		Sexually Transmitted		
			Disease		

Neuro-Psychological

	Seizures	Areas of Numbness	Concussion
	Twitches	Lack of Coordination	Depression
	Irritability	Loss of Balance	Stress
	Poor Memory	Anxiety	Mood Swings

	Tremors				

Gynecology

__	Age of Menses	Irregular Periods	Clots
__	Duration of Menses	Painful Periods	PMS
__	Date of Last Menses	Breast Lumps	Menopausal
__	# of Pregnancies	Spotting	Yeast Infections
__	# of Births	Vaginal Discharge	Fertility Problems

Musculo-Skeletal

__Arthritis
__Muscle Spasms
__Pain with Weather Changes
__ Muscle Weakness
__ Scoliosis
_Pain with Activity
__Muscle Cramping
__Weak Joints
__Pain After Waking

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