

CONTACT INFORMATION

**Richard A. Covello, L.Ac.
AcupunctureConnecticut .com**

Please complete the following:

Email Address: _____

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Person responsible for your account _____ Occupation _____

Who should we thank for referring you to this office? _____

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Office Use Only

Your CHSLife.com ID _____

Your CHSLife.com Password _____

PATIENT INFORMATION

Male Female Height_____ Weight_____ Birth Date_____

Marital Status: Single Married Divorced Widowed

Approximate date you were last examined by a physician (M.D). _____

Have you ever had acupuncture therapy before? Yes No

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any allergies, food sensitivities or food cravings that you have?

List any accidents; surgeries, or hospitalizations include dates.

Medications and supplements you are currently taking.

<i>Medicine</i>	<i>Reason</i>	<i>Dosage</i>	<i>How Long</i>	<i>Prescribed by</i>

Please **check** the box for any illnesses you or a blood relative (Grandparent, parent or sibling) has had:

	<i>YOU</i>	<i>RELATIVE</i>	<i>DATE</i>	<i>NOTES</i>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>		
Hepatitis	<input type="checkbox"/>	n/a		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Infectious Diseases	<input type="checkbox"/>	n/a		
Rheumatic Fever	<input type="checkbox"/>	n/a		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Tuberculosis	<input type="checkbox"/>	n/a		
STD (Syphilis, HPV, Herpes, Gonorrhea Chlamydeous)	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

Please check use and frequency of the following:

	<i>Yes</i>	<i>How Much</i>	<i>Notes</i>
Coffee / Black tea	<input type="checkbox"/>		
Non-Medical Drugs	<input type="checkbox"/>		
Tobacco	<input type="checkbox"/>		
Alcohol	<input type="checkbox"/>		
Water Intake	<input type="checkbox"/>		
Soda Pop	<input type="checkbox"/>		

Please indicate as follows (+) frequently experience, (-) sometimes experience.

	<i>Mark</i>		<i>Mark</i>		<i>Mark</i>
Lack of appetite		Abdominal Pain		Hemorrhoids	
Excessive appetite		Chest pain		Recent use of antibiotics	
Loose stool or diarrhea		Sciatic pain		Eye problems	
Digestive problems, indigestion		Headaches		Jaundice (yellow skin or eyes)	
Vomiting		Pain or coldness in the genital area		Difficulty digestion oily foods	
Belching, burping		Cough		Gall stones	
Heartburn / reflux		Shortness of breath		Light colored stool	
Feeling the retention of food		Decreased sense of smell		Soft or brittle nails	
Tendency to become obsessive in work,		Nasal problems		Easily angered or agitated	

Insomnia, difficulty sleeping		Skin problems		Difficulty making plans or decisions	
Heart palpitations		Feeling of claustrophobia		Spasms or twitching of muscles	
Cold hands and feet		Bronchitis		Low back pain	
Nightmares		Colitis or diverticulitis		Knee problems	
Mentally restless		Constipation		Kidney stones	
Laughing for no apparent reason		Hearing impairment		Decreased sex drive	
Angina pains		Ear ringing		Hair loss	
Urinary problems		Fatigue		Edema	
Blood in stool		Black tarry stool		Easily bruised	
Difficult to stop bleeding		Intolerance to weather changes		Tendency to catch colds easily	
Asthma		Allergies		Hay fever	
Dizziness		Tendency to faint easily		High cholesterol	
Sudden weight loss					

MALE

	<i>Date/ Number</i>	<i>Notes</i>
Date of Last Prostate Exam		
PSA Results		
Manual prostate exam results		
Lab Results		
Frequency of Urination Daytime		
Frequency of Urination Nighttime		
Color of Urine		

	<i>Yes</i>		<i>Yes</i>	<i>Notes</i>
Prostate Problems	<input type="checkbox"/>	Dribbling		
Rectal Dysfunction	<input type="checkbox"/>	Testicular Pain		
Incontinence	<input type="checkbox"/>			
Delayed Stream	<input type="checkbox"/>	Premature Ejaculation	<input type="checkbox"/>	
Increased / Decreased libido	<input type="checkbox"/>	Retention of Urine	<input type="checkbox"/>	
Groin Pain	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	
Testicular Pain	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	
Incontinence	<input type="checkbox"/>			
Other				

FEMALE

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>Notes</i>
Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Fibroids	<input type="checkbox"/>	
Are you trying to get pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Fibrocystic Breasts	<input type="checkbox"/>	
Number of pregnancies		<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	
Number of live births		<input type="checkbox"/>	Ovarian Cysts	<input type="checkbox"/>	
Number of Miscarriages		<input type="checkbox"/>	PID	<input type="checkbox"/>	
Number of Abortions		<input type="checkbox"/>	Other	<input type="checkbox"/>	
Age of first period (menarche)		<input type="checkbox"/>	Number of days of flow		
Age of last period (menopause)		<input type="checkbox"/>	Number of days between periods		
Color of flow			Clots	<input type="checkbox"/>	

	<i>Number</i>	<i>Date</i>	<i>Notes</i>
Average # of pads used 1 st day			
Average # of pads used 2 nd day			
Average # of pads used 3 rd day			
Average # of pads used 4 th			
+ days			
Last Gynecological Exam			
Last Mammogram			
Last Bone Density Exam			
Date of last Pap Smear			

<i>Pain</i>	<i>Yes</i>	<i>Other Symptoms</i>	<i>Yes</i>	<i>Notes</i>
Cramping	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	
Burning	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	
Dull Pain	<input type="checkbox"/>	Swollen breasts	<input type="checkbox"/>	
Constant Pain	<input type="checkbox"/>	Increased / Decreased Appetite	<input type="checkbox"/>	
Bearing Down Sensation	<input type="checkbox"/>	Increased / Decreased libido	<input type="checkbox"/>	
Stabbing Pain	<input type="checkbox"/>	Vaginal dryness	<input type="checkbox"/>	
Aching	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	
Bloating	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	
Intermittent Pain	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	
Night Sweats	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	
Insomnia	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	