



If you have any questions or if there is anything you wish to bring to my attention, that isn't asked in this form, please let me know. Your personal information is held in strict confidentiality. Thank you for your help.

Name: _____ Date of Birth: _____ Age _____

Ph: (H) _____ (Cell) _____ Height: _____ Weight: _____ Sex: _____

(W) _____ Email: _____ Occupation: _____

Address: _____ Emergency Contact: _____ Phone: _____

_____ zip _____ Referred By: _____

Chief Complaint : _____

When did the problem begin? _____

To what extent does it interfere with daily life? _____

Have you received a diagnosis for the problem? If so, what? _____

What treatment have you been using for relief of this issue? _____

Have you ever received used acupuncture? _____ For what reason _____

Severity of problem today: circle # below and area on diagram to right

| | | | | | | | | | | | |
|------------|---|---|---|---|---|---|---|---|---|----|------------------|
| No Problem | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Imaginable |
|------------|---|---|---|---|---|---|---|---|---|----|------------------|

Circle severity of problem in general

| | | | | | | | | | | | |
|------------|---|---|---|---|---|---|---|---|---|----|------------------|
| No Problem | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Imaginable |
|------------|---|---|---|---|---|---|---|---|---|----|------------------|

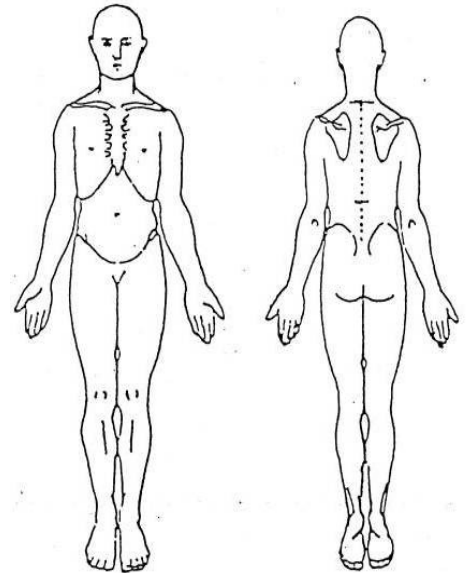
Family Medical History— elaborate and indicate which family member

Cancer _____ Heart Disease _____

Diabetes _____ High Blood Pressure _____

Drug/alcohol Abuse _____ Other _____

Other inherited or familial disease: _____



More about you

Surgeries & hospitalizations? _____ Allergies to drugs, chemicals, foods? _____

Stress in your life; chemical, occupational, physical, psychological: _____

What medications, supplements do you take? _____

Weekly exercise?: _____ Please describe your diet: _____

Indicate below your use of the following:

| | | | |
|--------------------------|-----------|-------------------|----------------|
| Tobacco _____ | per _____ | Age started _____ | Age quit _____ |
| Caffeine _____ | per _____ | Age started _____ | Age quit _____ |
| Alcohol _____ | per _____ | Age started _____ | Age quit _____ |
| Recreational drugs _____ | per _____ | Age started _____ | Age quit _____ |
| Other _____ | per _____ | Age started _____ | Age quit _____ |

General

Past Current

- Catch colds easily
- Recurrent infections
- Night sweats
- Sweat easily
- Bleed or Bruise easily
- Strong thirst
hot cold
- No desire to drink
- Fatigue / low energy
- Sudden energy drops
Time _____
- Sudden change in weight

Genito - Urinary

Past Current

- Pain on urination
- Urgent urination
- Frequent urination
- Blood in Urine
- Change in urinary flow
- Urinary incontinence
- Dribbling urination
- Wake at night to urinate
- Recurrent bladder infec-
- Recurrent yeast infections
- Kidney Stones
- Prostrate problems
- Change in sexual drive
- Impotence
- Rashes / Itching

Skin & Hair

Past Current

- Dry skin / scalp / hair
- Rashes / hives
- Itching

Skin & Hair (cont.)

Past Current

- Eczema
- Warts
- Acne
- Change in moles
- Hair loss / thinning hair
- Graying of hair

Sleep

Past Current

- Difficult to fall asleep
- Wake up easily –
times per night _____
- Wake too early –
times per night _____
- Nightmare
- Vivid dreams
- Grinding teeth
- Talking in sleep
- Sleepwalking
- Snoring
- Bad dreams

Cardiovascular

Past Current

- Pacemaker
- High blood pressure
- Low blood pressure
- Chest discomfort / pain
- Heart palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood clots
- Spider veins
- Fainting

Respiratory

Past Current

- Pain with breathing
- Difficulty with breathing
- Shallow breathing
- Shortness of breath
- Production of phlegm

Respiratory (cont.)

Past Current

- Recurrent / chronic cough
- Asthma / wheezing
- Bronchitis
- Emphysema
- Pneumonia

Gynecological

Past Current

- Irregular periods
- Painful periods
- Premenstrual syndrome
- Menopausal syndrome
- Abnormal PAP smear
- Abnormal bleeding
- Postcoital bleeding
- Clots
- Fibroids
- Endometriosis
- Infertility
- Vaginal dryness
- Vaginal discharge
- Vaginal sores
- Breast lumps
- Nipple discharge

Are you pregnant? yes no

Do you practice birth control?
yes no

What type _____

How long _____

of pregnancies _____

of births _____

of premature births _____

of abortions _____

Age of first menses _____

days between menses _____

Duration of menses _____

1st day of last menses _____

Age of menopause _____

Date of last PAP _____

Neurological

Past Current

- Seizures
- Paralysis
- Tremors
- Stroke
- Concussion
- Nerve Damage
- Numbness / tingling
- Dizziness / vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty concentrating

Psychological

Past Current

- Depression
- Manic Behavior
- Anxiety / nervousness
- Panic attacks
- Often stressed
- Easily angered
- Easily angered
- Aggressive behavior
- Lose control of emotions
- Substance abuse

Have you been treated for emotional problems? yes no

Have you ever considered suicide? yes no

Head/ Eyes / Ears

Past Current

- Headaches
- Where
- When
- Migraines

Head / Eyes / Ears Nose / Throat (cont.)

Past Current

- Dizziness / vertigo
- Earache
- Discharge form ear
- Change in hearing
- Ringing in ears
- Blurry vision
- Night blindness
- Spots before eyes
- Sore eyes
- Excessive tearing
- Glasses / contacts
- Facial pain
- Nosebleeds
- Nasal discharge
- TMJ
- Teeth / gum problems
- Recurrent sore throat
- Hoarseness / loss of voice
- Tonsillitis / swollen glands
- Sores on lips/ mouth/gums

Musculoskeletal

Past Current

- Neck pain
- Shoulder pain
- Back pain
- Hand /wrist pain
- Knee pain
- Foot / ankle pain
- Joint / bone problems
- Muscle pain / weakness
- Osteopenia / osteoporosis
- Herniated disc
- Sciatica
- Other _____

Digestive

Past Current

- Little appetite
- Strong appetite
- Bad Breath
- Belching
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Abdominal Pain
- Weight gain
- Weight loss
- Loose stools / diarrhea
- Abnormal stools
- Constipation
- Gas / flatulence
- Gall bladder problems
- Hernia
- Hemorrhoids
- Anorexia nervosa
- Bulimia

Infection Screening

Have you ever tested positive? When?

- HIV _____
- Tuberculosis _____
- Hepatitis _____
- Gonorrhea _____
- Syphilis _____
- Herpes (oral / genital) _____