

Name: (Last, First)			Date of Birth:		
Address:		City:		Stat:	Zip code:
Phone:	Phone: (work, cell)	Email:			
Sex:	Emergency Contact:	Contact #:	Contact Relationship:		
Occupation:			Have you been treated with acupuncture previously: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: ____/____/____		

Main Concerns

Write in your top 3 concerns in order of importance to you and circle the choice that best describes the condition.

<p>1 _____</p> <p>When did it start? _____</p> <p>Heat makes it: Better No Change Worse</p> <p>Cold makes it: Better No Change Worse</p> <p>Heat makes it: Better No Change Worse</p> <p>Damp weather: Better No Change Worse</p> <p>Windy weather: Better No Change Worse</p> <p>Exercise/activity: Better No Change Worse</p> <p style="text-align: center;"><u>Discomfort level 0 —10?</u></p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>	<p>2 _____</p> <p>When did it start? _____</p> <p>Heat makes it: Better No Change Worse</p> <p>Cold makes it: Better No Change Worse</p> <p>Heat makes it: Better No Change Worse</p> <p>Damp weather: Better No Change Worse</p> <p>Windy weather: Better No Change Worse</p> <p>Exercise/activity: Better No Change Worse</p> <p style="text-align: center;"><u>Discomfort level 0 —10?</u></p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>	<p>3 _____</p> <p>When did it start? _____</p> <p>Heat makes it: Better No Change Worse</p> <p>Cold makes it: Better No Change Worse</p> <p>Heat makes it: Better No Change Worse</p> <p>Damp weather: Better No Change Worse</p> <p>Windy weather: Better No Change Worse</p> <p>Exercise/activity: Better No Change Worse</p> <p style="text-align: center;"><u>Discomfort level 0 —10?</u></p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p>
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Health History

	YOU	When	FAMILY		YOU	When	FAMILY		YOU	When	FAMILY
Cancer: _____		_____	IIII	Osteoporosis		_____	IIII	Kidney Disease		_____	IIII
Hepatitis: _____		_____	IIII	Heart Disease		_____	IIII	Autoimmune		_____	IIII
Allergies: _____		_____	IIII	Stroke		_____	IIII	Seizures		_____	IIII
High Blood Pressure		_____	IIII	Thyroid Disease		_____	IIII	Asthma		_____	IIII
Pacemaker		_____	IIII	Anemia		_____	IIII	Rheumatic Fever		_____	IIII
Alcoholism		_____	IIII	Other: _____							

Medications

Please list any medications your are currently taking

Surgeries

Please list all surgeries and hospitalizations

Dietary Habits/Restrictions

Please list any dietary habits or restrictions

Social Habits

Tobacco Use: _____

Alcohol: _____

Caffeine: _____

Recreational Drug: _____

Temperature

- Cold hands/feet
- Chills
- Cold "deep or to the bone"
- Areas of numbness
- Thirsty but no desire to drink
- Absence of thirst
- Excessive thirst
- Thirst for cold/hot drinks
- Night sweats
- Unusual sweats
- Time ____am/pm
- Where _____
- Hot hands/feet
- Hot flashes
- Hot in the afternoon
- Hot at night

Moisture

- Dry skin/hair/nails
- Dry eyes
- Dry nose/nosebleeds
- Dry lips
- Dry Throat
- Dry Mouth
- Edema/Swelling ____where on body
- Rashes _____
- Itching _____
- Oily skin/hair
- Pimples
- Weight gain / loss

Digestion

- BM: How often? ____ x / every ____ days
- Stools keep shape? Yes No
- Alternating diarrhea/constipation
- Indigestion
- Gas/Bloating
- Belching
- Poor appetite
- IBS
- Nausea / Vomiting
- Bad Breath
- Heartburn
- Excessive hunger
- Dry Stools
- Difficult to pass
- Tired after BM
- Foul Smelling Stools

Energy

- Sudden energy drop
- Time of Day: _____
- Energy drop after eating
- Fatigue
- Dependence on Caffeine
- Wired/ungrounded feeling
- Body / Limbs feel heavy
- Body / Limbs feel weak
- Shortness of Breath
- Heart Palpitations
- Blood pressure high / low
- Bleed / Bruise easily
- Hard to concentrate
- Poor Memory
- Dizziness/lightheaded
- Headaches ____ / week

Sleep

- # Hours per night _____
- Difficulty falling asleep
- Wake ____ x night @ ____ am / pm
- Wake to urinate *How Often?* _____
- Disturbing dreams
- Restless sleep
- Not rested on waking

Emotions

- Anger
- Irritability
- Anxiety
- Worry
- Obsessive Thinking
- Sadness
- Grief
- Depression
- Joy
- Fear
- Timid/Shy
- Indecision

Eyes, Ears, Nose Throat

- Poor vision
- Night blindness
- Red eyes
- Itchy eyes
- Spots in front of eyes
- Sinus congestion
- Phlegm (color _____)
- Poor Hearing
- Ringing in the ears
- Excess ear wax
- Sore throat
- Dental problems
- Mouth sores
- Cough

Hormonal Balance

- Age at first menses: _____
- Length of full cycle: ____ days
- Length of menses: ____ days
- Last menses start date: ____/____
- # of pregnancies: ____
- # of births: ____ premature: ____
- # of miscarriages/abortions: ____
- Heavy periods
- Light Periods
- Painful periods
- Irregular periods
- Changes in body/psyche prior to menstruation
- Cramps
- Before bleeding
- First day
- During period
- Clots
- Breast tenderness
- Mood changes
- Fatigue with menses
- Digestive changes w/menses
- Midcycle spotting
- Yeast infections

Hormonal changes

- Age at last menses: _____
- Year changes began: _____
- Hot flashes: ____x/day
- Night Sweats: ____x/day
- Vaginal dryness
- Loss of sex drive

Other: _____

Urinary

- Fluid in = Fluid out Yes No
- Decrease in flow/dribbling
- Difficulty in starting/stopping
- Incontinence
- Kidney stones
- Urgent Urination
- Frequent Urination
- Pain/burning sensation
- Cloudy urine
- Blood in urine

Other

- Change in sex drive ↓ ↑
- Erectile dysfunction
- Premature ejaculation
- Infertility
- Discharge
- Prostate disease
- Genital pain
- Fibroids/cysts
- Hernia
- Hemorrhoids

Any other complaints or information you would like us to know: _____

Signature: _____ Relationship to patient _____ Date: ____ / ____ / ____