

PATIENT INFORMATION

Date: _____

Name: _____

Home address: _____

Home phone: _____

Mobile phone: _____

email: _____

Who referred you? _____

Emergency contact: _____

Physician: _____

Date last physical exam: _____

Have you received acupuncture before? If yes, date? Treated by? What were the results?

Date of birth: _____

Employer: _____

Business address: _____

Business phone: _____

Emergency phone: _____

Physician phone: _____

Physician email: _____

Major complaint: _____

What caused it? _____

Have you received treatment for this condition? If yes, date? Treated by? What were the results?

What makes it better? _____

What makes it worse? _____

Indicate any significant illnesses you or a blood relative (grandparent, parent, sibling, child) have had:

cancer _____

hepatitis _____

hypertension _____

rheumatic fever _____

STD _____

diabetes _____

heart disease _____

seizures _____

TB _____

other _____

List accidents, surgeries. Include date.

List medications/supplements currently taking. Include dosage, how long on med, prescribed by?

Indicate the use and frequency of the following:

coffee/tea _____

non-medical drugs _____

tobacco _____

alcohol _____

water _____

soda _____

List any allergies, food sensitivities or food cravings you have:

Indicate which symptoms you are currently experiencing:

1. Chills/Fever

- sudden chills/fever
- alternating chills/fever
- low grade afternoon fever
- fever worsens in the afternoon
- chronic low grade fever

2. Sweating

- spontaneous sweat with no exertion
- daysweats
- night sweats
- sweating only on head
- sweating only on forehead
- sweating only on hands
- sweating on 4 limbs
- sweating on whole body
- sweating on palms/soles/chest

3. Head/Body

- sudden headache/neckache
- headache worse during day
- headache worse during night
- headache with empty head feeling
- 1 sided splitting headache
- headache at neck nape
- headache at forehead
- headache at temple
- headache at top of head
- head heaviness
- sudden dizziness/vertigo
- chronic dizziness/vertigo
- 1 sided body numbness
- 2 sided body numbness
- varicose veins
- blood clot
- edema
- cold hands/feet
- joint swelling
- dry skin
- rash
- acne
- hair loss/graying
- eczema/psoriasis
- brittle/soft nails
- fungal infection

4. Chest/Abdomen

- chest pain
- chest pain with cough
- angina pectoris
- palpitations
- rib pain
- epigastric pain
- abdominal pain
- low abdominal pain
- lumbar pain
- intestinal pain/cramping
- acid reflux/heartburn
- asthma/shortness of breath
- difficult inhalation/exhalation
- diagnosed heart disease

5. Food/Taste

- prefers sweet/sour/salty food
- sweet/sour/salty/bitter taste in mouth
- no taste
- vomit after eating
- vomit after drinking
- nausea
- belching/burping
- acid reflux
- difficult digestion

6. Urine/Stool

- incontinence/retention
- urination during laughing/sneezing
- incomplete urination
- dribbling urination
- pain before urination
- pain during urination
- pain after urination
- pale colored urine
- dark colored urine
- copious urine
- scanty urine
- hot urine
- milky urine
- odor
- wake frequently to urinate
- bedwetting
- kidney stone
- sudden loose stool/diarrhea
- chronic loose stool/diarrhea
- urgent diarrhea
- early morning diarrhea @ 5am
- diarrhea after eating
- sudden constipation
- chronic constipation
- small, itty, bitty stools like a goat
- alternating diarrhea/constipation
- constipation after pregnancy
- discomfort better after bowel movement
- light colored stool
- blood/mucus in stool
- black tarry stool
- incomplete evacuation
- hemorrhoids

7. Sleep

- difficult falling asleep but stays asleep
- falls asleep easily but wakes often
- frequent dreams
- wake up not feeling rested
- wake up at specific time

8. Thirst/Drink

- no thirst
- excessive thirst
- thirst but no desire to drink
- thirst for cold/warm liquid
- no appetite
- insatiable appetite
- hunger but no desire to eat

9. Ears/Eyes/Nose

- eye pain/swelling/redness
- eye twitch
- facial muscle twitch
- abnormal eye movements
- blurred vision/floaters
- night blindness
- dry eyes
- yellow sclera
- facial paralysis
- facial edema
- ear pain/discharge
- sudden tinnitus
- gradual tinnitus
- sudden deafness
- gradual deafness
- nasal obstruction
- nosebleed
- postnasal drip
- decreased smell
- bitter taste/decreased taste
- sorethroat
- cough with sputum
- cough with no sputum
- mouth/tongue ulcer
- difficult swallowing
- feeling of lump in the throat

10. Pain

- sudden pain
- chronic pain
- cold pain
- hot pain
- sharp pain
- dull pain
- stabbing pain
- distending pain
- burning pain
- intermittent pain
- bearing down sensation
- moves from location to location
- better with heat/cold
- better with pressure
- better with rest
- worse with dampness

11. Other

- anxiety/mental restlessness
- irritability
- depression
- stress
- poor memory
- seasonal mood swings
- libido change
- sighs frequently
- sudden weight loss
- tendency to catch colds easily
- bleed/bruise easily
- high/low blood pressure
- high cholesterol
- osteoporosis

For Women

- _____ age of first period
- _____ age of last period
- _____ spotting between periods
- _____ number of days of flow
- _____ number of days between periods
- _____ color of flow (light red, dark red, bright red)
- _____ quantity of flow (scanty, heavy, alternating scanty/heavy)
- _____ quality of flow (watery, thin, thick)
- _____ clots

Pregnancy

- _____ are you pregnant?
- _____ number of pregnancies
- _____ number of live births
- _____ number of abortions
- _____ number of miscarriages
- _____ miscarriage before 3 months
- _____ miscarriage after 3 months
- _____ nausea/heavy bleeding after delivery
- _____ sweating/fever after delivery
- _____ postnatal depression

Pain

- _____ head
- _____ low abdomen
- _____ low back
- _____ other
- _____ during ovulation
- _____ before menses
- _____ during menses
- _____ after menses
- _____ sudden
- _____ chronic
- _____ dull
- _____ stabbing
- _____ burning
- _____ distending
- _____ intermittent
- _____ bearing down sensation

- _____ birth control type
- _____ how long on current birth control
- _____ date of last OB/Gyn exam
- _____ date of last Pap smear
- _____ date of last mammogram
- _____ date of last bone density scan
- _____ results: _____
- _____
- _____

- _____ fibroids
- _____ fibrocystic breasts
- _____ endometriosis
- _____ ovarian cysts
- _____ pelvic inflammatory disease
- _____ hysterectomy (partial, full)
- _____ hormone replacement therapy
- _____ infertility

Symptoms currently experiencing

- _____ vaginal discharge (white, yellow, thick, clear)
- _____ discharge consistency (watery, thick)
- _____ vaginal odor (fishy, leathery)
- _____ vaginal dryness
- _____ vaginal itching
- _____ nausea/vomit
- _____ swollen breasts
- _____ hot flashes
- _____ night sweats
- _____ diarrhea during menses
- _____ constipation during menses
- _____ acne during menses
- _____ weight gain/loss
- _____ irritability
- _____ depression

For Men

Prostate

- _____ date of last prostate exam
- _____ PSA results _____
- _____
- _____

Pain Location

- _____ inguinal
- _____ groin
- _____ testicle
- _____ back
- _____ knees

- _____ rectal dysfunction
- _____ premature ejaculation
- _____ impotence
- _____ libido change
- _____ frequent daytime urination
- _____ frequent nighttime urination