

☯ Acupuncture & Herbs

Full name:		Date:	
Date of Birth:	Age:		
Phone: Home #	Work #	Cell #	
Address:	City:	State:	Zip:
Occupation:	E-mail:		
Emergency contact:	Phone #	Relationship:	
Physician:	Phone #	May we contact them? <input type="checkbox"/> Y <input type="checkbox"/> N	
Do you have health insurance? Y N			
Have you been treated by acupuncture before? Y N			
How did you hear about us?			
Signature: _____			

Main Concerns (include duration):

Have you been given a diagnosis? If so what?

What kind of treatments have you tried?

What do you think may be the cause of your health concerns?

What alleviates your symptoms?

What aggravates your symptoms?

Is there anyone in your family with the same/similar problems?

Past Medical History:

- Significant Illness:** Cancer Diabetes Hepatitis Thyroid Disease Seizures
 Fibromyalgia Arthritis Tuberculosis Hypertension Emotional Imbalance
 Heart Disease Anemia Digestive Disorders Breathing Problems HIV/AIDS Positive
 Venereal Disease Other: _____

Family Medical History (Please write in family member):

- Cancer _____ Diabetes _____ Hepatitis _____
 Hypertension _____ Heart Disease _____ Stroke _____
 Asthma _____ Alcoholism _____ Miscarriage _____
 Other: _____

Hospitalizations / Surgeries: _____

Significant trauma (auto accidents, sports injuries, etc.): _____

Allergies (drugs, foods, chemicals): _____

Medicines taken in the past 3 months (include vitamins, OTC drugs, herbs etc.):

Medicine:	Reason for taking:	Dose:

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height _____ Weight now _____ One year ago _____ Max Weight _____ In year _____

Habits: Do you smoke? Y N What? _____ How much/day? _____ Since _____

Do you take recreational drugs? Y N What? _____

Do you exercise regularly? Y N Please describe: _____

How many hours do you sleep in general? _____ When do you go to bed? _____

Diet: How much caffeine do you drink/day? (Include: coffee, tea, colas, etc.): _____

Kind of alcohol you usually drink, if any? _____ Avg. # of drinks/week _____

How much water do you drink per day? _____

Are you a vegetarian? Y N Do you eat a lot of spicy food? Y N

Please describe your average daily diet (be as specific as possible):

- Morning:
- Afternoon:
- Evening:
- Snacks:

Rate your relationship with the following by indicating either: poor (P), fair (F), well (W), or great (G):

Health _____ Work _____ Yourself _____ Others _____

Contributing factors to lack of personal optimum health (check all that apply):

- Lack of motivation Lack of information Lack of time
 Contradictory information Inability to follow through Circumstance

Areas that you feel could be improved in your life (check all that apply):

- Diet Physical activity Time management Priorities Outlook
 Other: _____
-

Please check if you have or have had any of the following conditions within the past 3 months:

- General:** Poor sleeping Fatigue Fevers Chills Night sweats Sweat easily
 Tremors Cravings Poor appetite Change in appetite Poor balance
 Localized weakness Bleed or bruise easily Weight Loss Weight Gain
 Peculiar taste Desire hot food Desire cold food Strong thirst (cold or hot)
 Sudden energy drop - time of day _____ Favorite season _____ Least favorite season _____
-

- Skin & Hair:** Rashes Ulcerations Hives Itching Eczema Acne
 Dandruff Dry Skin Recent Moles Loss of hair Purpura Change in hair or skin texture
Other: _____
-

- Musculoskeletal:** Joint disorders Weakness in muscles Pain/Soreness in muscles Tremors
 Difficulty walking Cold hands/feet Swelling of hands/feet Back Pain Spinal Curvature
 Hernia Numbness Tingling Paralysis Neck Tightness Shoulder pain
 Neck pain Hand/wrist pain Hip pain Knee pain Sprain of joint
 Other: _____
-

- Head, Eyes, Ears, Nose, and Throat:** Dizziness Concussions Migraines Glasses/lens
 Eye Strain Eye Pain Color Blindness Night Blindness Poor vision Cataracts
 Blurry vision Earaches Ringing in ears Poor hearing Spots in front of the eyes
 Sinus problems Nose bleeding Sore throat Grinding teeth Teeth problems
 Facial pain Jaw clicks Sores on lips/tongue Difficulty swallowing
 Other: _____
-

Cardiovascular: High Blood Pressure Low Blood Pressure Chest pain Palpitation
 Fainting Phlebitis Irregular heartbeat Rapid heartbeat Varicose Veins
 Other: _____

Respiratory: Cough Coughing blood Wheezing Difficulty in breathing Bronchitis
 Pneumonia Chest pain Production of phlegm - What color? _____
 Other: _____

Gastrointestinal: Nausea Vomiting Diarrhea Constipation Gas Belching
 Black Stools Blood in stools Indigestion Bad breath Rectal Pain Hemorrhoid
 Abdominal cramps/pain Gallbladder problem Parasites Chronic laxative use
Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____
 Other: _____

Neuro-psychological: Loss of Balance Lack of Coordination Concussion Depression
 Anxiety Stress Bad temper Bi-polar Other: _____

Genito-urinary: Pain on urination Frequent urination Blood in urine Urgency to urinate
 Kidney Stones Unable to hold urine Dribbling Pause in flow Frequent urinary tract infection
 Pain in genital Itching of genital Other: _____

Female: Frequent vaginal infections Pelvic infection Endometriosis Vaginal discharge
 Fibroids Ovarian cysts Irregular periods Clots Pain/cramps prior/during periods
 Breast tenderness Breast lumps Fertility Problems Moodiness related to periods
 Low libido Hot Flashes Vaginal dryness Other: _____
_____#of pregnancies _____#of births _____Miscarriages _____Abortions _____Premature Births

Male: Prostate problems Impotence Frequent seminal emission Painful/swollen testicles
 Fertility problems Discharge Ejaculation problems Other: _____

I understand the above information and have completed this form to the best of my knowledge.

I have been evaluated by a physician for the condition(s) being treated within the past 12 months.

Signature: _____ Adult patient Parent or guardian