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## Patient Information

(Please Print)

Name: _____ Today's Date: _____

Home Address: _____ Age: _____

_____ Date of Birth: _____

Home Phone: ( ) _____Cell Phone: ( ) _____

Work Phone: ( ) _____Email: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed Height: _____ Weight: _____

Emergency Contact: _____ Relationship to Patient: _____

**Emergency Contact's Phone Number: ( ) _____**

Primary Care Physician (PCP): _____ PCP City/State: _____

PCP Phone Number: ( ) _____ Date of last medical examination: _____

## Health History

1. Have you had acupuncture before? _____ Yes _____ No Have you eaten today? ____ Yes ____ No

2. **Reason for today's visit?** _____

3. Was there a Physician's diagnosis? _____

4. Has there been anything that has ever been able to change this health concern in any way?

____ Yes ___ No If Yes, please describe: _____

5. When did this problem first appear? _____

6. Is it constant or does it come and go? _____

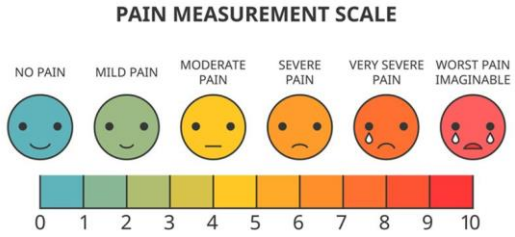
7. If applicable, does the problem ever move? (For example: pain or spasms that occur in different joints or muscles at different times) _____ Yes _____ No

## Health History (con't)

8. Do you have a history of chronic pain? _____ Yes _____ No

9. Describe the type of pain: ____ Dull ____ Aching ____ Stabbing ____ Throbbing

10. Are you experiencing pain right now? ____ Yes ____ No

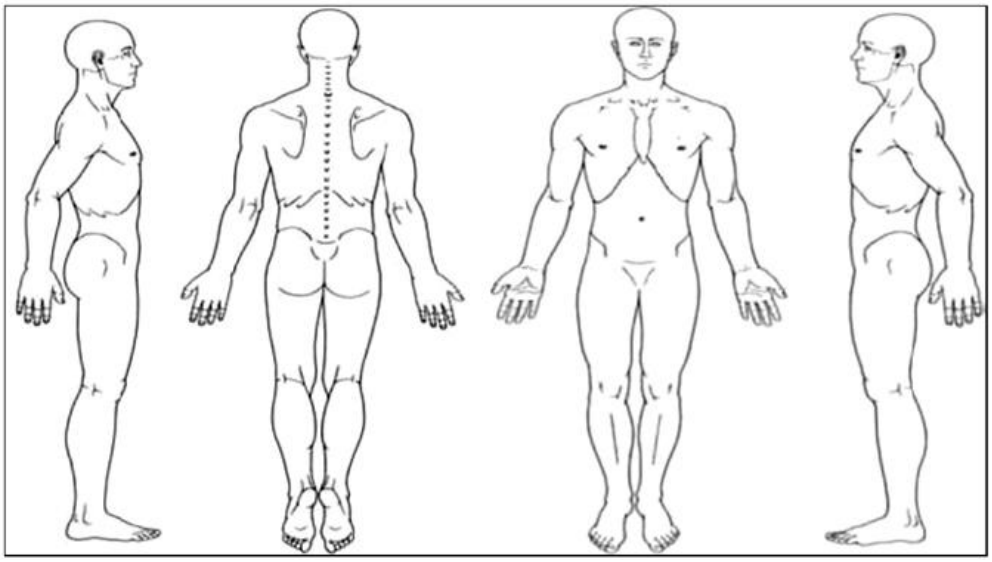



11. If yes, what number best describes your pain? _____

12. What is the frequency of pain? ___ Continuous ___ Intermittent

13. What makes your pain better? ____ Heat ____ Cold _____ Pressure _____ Rest ____ Movement
(select all that apply)

Please mark your areas of pain on the diagram.



14. Is your health concern affected by seasonal changes? _____ Yes ____ No

15. Are there any other problems or health concerns you would like to be addressed: _____

_____

16. Do you have any allergies? (Food, medication, seasonal, animals, etc) ____ Yes ____ No
If yes, please list:

_____

17. Do you have any infectious diseases? ____ Yes _____ No If yes, please list:

_____

## Medications & Supplements

Please list all medications (prescription and over-the-counter), supplements and/or herbs that you are CURRENTLY taking:

| Medications, supplements, or herbs: | For what problem/concern: |
|---|---|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |
| 5. _____ | 5. _____ |
| 6. _____ | 6. _____ |
| 7. _____ | 7. _____ |
| 8. _____ | 8. _____ |

## Personal Medical History

Vaccination History:  Any unusual reaction?

_____

Please list any surgeries, accidents, major illnesses and/or medical conditions that you have been diagnosed with.  Please list in chronological order and indicate duration of illness.

Age: _____ _____

Age: _____ _____

Age: _____ _____

Age: _____ _____

Age: _____ _____

Age: _____ _____

## Family Medical History

| | Age | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brother(s) | | | | |
| | | | | |
| | | | | |
| | | | | |
| Sister(s) | | | | |
| | | | | |
| | | | | |
| | | | | |

| Family Health History | Yes | No | Relationship |
|---|---|---|---|
| Diabetes | | | |
| Kidney Disease | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| Arthritis | | | |
| Cancer | | | |
| Stomach Disease | | | |
| Psychological Illness | | | |
| Epilepsy/Convulsions | | | |
| Respiratory Condition | | | |

## Lifestyle Information

### Habits

1. Do you smoke tobacco? Yes _____ No _____ How many per day? _____ Since when?_____
2. Do you drink alcoholic drinks? Yes _____ No ____
   What kind? _____ Average # of drinks per week? _____
3. Do you drink coffee (or other caffeinated drinks)? Yes _____ No _____How many a day? _____
4. Do you exercise? No _____ Moderately _____ Heavy _____
5. How much water do you drink per day? _____

### Sleep

1. What time do you usually go to bed at night? _____
2. How many hours do you sleep in general? _____
3. Do you wake very early & then are unable to go back to sleep? Yes _____ No _____
4. Do you experience any of the following:
   a. difficulty falling asleep Yes _____ No _____ d. wake easily Yes _____ No _____
   b. dream-disturbed sleep Yes _____ No _____ e. sleep apnea Yes _____ No _____
   c. grind your teeth Yes _____ No _____

### Diet

1. Has there been any changes in your appetite? Yes _____ No _____
   If yes, explain: _____
2. Do you have a strong thirst? Yes _____ No _____
3. Do you have certain cravings? Yes _____ No _____ If yes, explain: _____
4. Do you have a peculiar taste in your mouth? Yes _____ No _____
   If yes, explain: _____
5. Have you had any recent weight loss or weight gain? Yes _____ No _____
6. Do you tend to get sleepy or fatigued after eating? Yes _____ No _____
7. When given a choice, do you prefer cold or hot beverages? Cold _____ Hot _____
8. Do you prefer to consume cold or hot foods? Cold _____ Hot _____

**Symptom Overview:** please check all that apply

## MUSCULOSKELETAL

| | | | | | |
|---|---|---|---|---|---|
| | Joint clicking | | Limitation of movement | | Pain or stiffness |
| | Spasms or cramps | | Swelling | | weakness |
| Where in body: | | | | | |

## EYES, EARS, NOSE, & THROAT

| | | | | | |
|---|---|---|---|---|---|
| | Loss of vision | | Eye pain | | Eye tearing |
| | Ear pain | | Loss of hearing | | Ringing in ears |
| | Balance problems (vertigo) | | Sense of smell impaired | | Nose stuffiness |
| | Nose bleeds | | Sinus pain | | Eye floaters |
| | Other: please list: | | | | |

## RESPIRATORY

| | | | | | |
|---|---|---|---|---|---|
| | Chest pain, tightness | | Coughing up blood | | Shortness of breath |
| | Sore throat | | Sputum production | | Wheezing |
| | Chronic cough | | Difficulty breathing when lying down | | |
| | Other: please list: | | | | |

## CARDIOVASCULAR

| | | | | | |
|---|---|---|---|---|---|
| | Chest pain &/or pressure | | Edema | | Fainting |
| | Fatigue | | Palpitations | | Skin ulcerations |
| | Swelling of ankles &/or legs | | Other: please list | | |

## DIGESTIVE

| | | | | | |
|---|---|---|---|---|---|
| | Abdominal distention/bloating | | Abdominal mass | | Abdominal pain |
| | Acid regurgitation &/or heartburn | | Alternating constipation/diarrhea | | Rectal bleeding |
| | Constipation | | Diarrhea | | Gas |
| | Eating disorder | | Indigestion | | Jaundice (yellow tint to skin &/or eyes) |
| | Nausea | | Vomiting | | Poor appetite |
| | Bowel movement 1x day | | Bowel movement more than 1x day | | Bowel movement less than 1x day |
| | Hemorrhoids | | Increased appetite | | Burning anus |
| | Other: please list: | | | | |

## UROGENITAL

| | | | | | |
|---|---|---|---|---|---|
| | Difficulty with urine flow | | Incontinence | | Painful urination/pelvic pain |
| | Rashes | | Red urine | | Urinary tract infection (UTI) |
| | Wake up to urinate during night | | Dribbling urination | | |
| | Other: please list: | | | | |

## **Symptom Overview (con't):** please check all that apply

### NEUROLOGICAL

| | | | | | |
|---|---|---|---|---|---|
| | Changes or loss of consciousness | | Confusion | | Difficulty concentrating |
| | Dizziness | | Dysphagia (impaired ability to speak) | | Difficult balance when walking |
| | Headache | | Numbness &/or tingling | | Visual disturbance |
| | Paralysis | | Post shingles pain | | Problems coordinating movements |
| | Severe forgetfulness | | Tremor | | Weakness |
| | Other: please list: | | | | |

### INTEGUMENTARY (SKIN)

| | | | | | |
|---|---|---|---|---|---|
| | Changes in hair | | Changes in nails | | Changes in skin color |
| | Itching (prurites) | | Never sweat | | Rash &/or skin lesion |
| | Unusual sweating | | Wounds that will NOT heal | | Night sweating |
| | Other: please list: | | | | |

### PSYCHOLOGICAL

| | | | | | |
|---|---|---|---|---|---|
| | Feelings of grief | | Feelings of sadness | | Feeling fearful/anxious/nervous |
| | Difficulty managing anger | | Feeling manic | | Feeling worried |
| | Feelings of panic | | Feeling overwhelmed | | Extreme mood swings |
| | Extreme lack of emotion | | Other: please list: | | |

### MISCELLANEOUS

| | | | | | |
|---|---|---|---|---|---|
| | Low energy | | Frequent colds/flu | | Mental cloudiness |
| | Other: please list: | | | | |

### FOR MEN

| | | | | | |
|---|---|---|---|---|---|
| | Prostate problems | | Fertility concerns | | Sexual dysfunction |
| | Unusual discharge | | Other: please list: | | |

### FOR WOMEN

| | | | | | |
|---|---|---|---|---|---|
| | Abnormal vaginal bleeding | | Changes in hair distribution | | Fertility concerns |
| | Irregular menstruation | | Menopausal symptoms | | No menses |
| | Pain with menses | | Pain during after sexual relations | | Pelvic pain |
| | Premenstrual symptoms | | Sexual dysfunction | | Unusual discharge |

| | | |
|---|---|---|
| Age of first menses: | Duration of periods: days | Date of last period: |
| Date of last Mammogram: | Date of last PAP: | Age of Menopause: |
| Are you trying to become pregnant? YES _____ NO _____ | | |
| Have you ever been pregnant? YES _____ NO _____ If Yes, please answer below: | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | # of pregnancies | | # of births | | # of miscarriages | | # of abortions |