Medical Information (all information kept in strictest confidence)

<PLEASE PRINT> Date: ____/____/____

Name _____ Age _____ Sex □ Male □ Female

Address _____City State Zip _____

Occupation _____Date of Birth ___/___/___

(W) ( )_____ex _____ (C) ( )_____

(H) ( )_____ Email: _____

Referred by _____

Physician _____ Tel. ( ) _____

What do you want treated with acupuncture? _____

How long have you had this? _____ The onset was: □Sudden □Gradual

Symptoms relieved by _____ Symptoms worsened by _____

What medical diagnosis have you received? _____

What other treatments have you received recent1y for this? _____

Are you taking any medication? Please note all medication, (including all birth control) herbs, vitamins and minerals you take even if you take them only occasionally.

_____

_____

For what condition(s)? _____

In general, do you feel hot or cold? _____ Do you have chills or fever? _____

Are you currently pregnant? □ Yes □ No Are you trying to get pregnant? □ Yes □ No

On the following box, please list issues and areas to be addressed and medications/supplements that you are taking:

PAST MEDICAL HISTORY

Have you had any of these? Please check ALL that apply:

□ AIDS/HIV □ Alcoholism □ Allergies (food, latex)□ Asthma □ Birth Trauma (your own birth) □ Cancer □ Chronic Fatigue □ Diabetes □ Emphysema □ Fibromyalgia □ Heart Disease □ Hepatitis A/B/C □ Herpes □ Lyme Disease □ Multiple Sclerosis □ Pacemaker □ Polio □ Rheumatic Fever □ Scarlet Fever □ Seizures □ Seasonal Allergy □ Sinus infection □ Tuberculosis □ Operations(appendix, lymph glands)/Other:

_____

Describe any significant injuries, surgeries, or major illnesses, whether hospitalized or not, and the dates:

_____

_____

_____

FAMILY MEDICAL HISTORY (Please list any significant family illnesses)

Please note all major illnesses in your family of origin such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, et cetera.

Mother _____

Father _____

Siblings _____

Paternal Grandparents _____

Maternal Grandparents _____

EXERCISE & ENERGY

How is your energy? _____

What time of day is your energy: Highest? _____ Lowest? _____

Do you fatigue easily? □ Yes □ No _____

What kind of exercise do you do? _____

How often do you exercise? _____

How much water do you drink each day? _____

EMOTIONS & SLEEP

How do you feel emotionally? _____

Do you have (Check ALL that apply) □ Panic/ fear attacks □ Depression □ Anxiety □ Bad Temper □ Nervousness □ Fear attacks □ Poor memory □ Difficult concentration □ Other _____□ Married / Stable Relationship □ Single

How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

How do you feel about your work? _____

How long do you normally sleep? _____ hours per night. Is it enough? □ Yes □ No

Do you waken feeling refreshed? □ Yes □ No I have difficulty with: □ Falling asleep □ Staying asleep □ Disturbed sleep □ Interrupted-Waking up at about ____AM / PM and not being able to fall asleep again because: _____

GASTROINTESTINAL

I have (Check ALL that apply) □ Belching □ Nausea □ Vomiting □ Vomiting Blood □ Ulcers □ Bloating □ Acid Reflux □ Heartburn □ Hernia □ Indigestion □ Severe Stomach Pain

Bowel Movements: How often? ____ Day/Week □ Undigested food in stool □ Loose stool □ Irregular BM □ Constipation □ Diarrhea □ Gas □ Burning □ Hemorrhoids □ Use Laxatives □ no appetite □no stomach acid □illeocecal valve spasm □ Hard stool □ Blood in stool

□ Itchiness Painful Bowel Movement? □ Yes □ No □ Other _____

URINARY & GENITAL

Urination How often? ____ times per day Color: □ Pale yellow □ Dark yellow/orange
I have or have had (Check ALL that apply): □ Trouble starting stream □ Frequent urination
□ Incontinence □ Pain □ Trouble holding urine □ Burning □ Dribbling when sneezing
□ Urinary tract infections □ Blood in urine □ Kidney stones □ Other _____
How is your libido? _____Do you have: □ Infertility □ Pain during sexual relations □ Other _____

Women: At what age did you start menstruating? _____ Number of days of flow _____
Number of days between cycles? _____ Color_____ I have or have had:
I have or have had (Check ALL that apply): □ Irregular menstruation □ Heavy flow
□ Light flow □ No flow □ Clots □ Vaginal itching/ burning □ Spotting between periods
□ Discomfort / pain before period □ Discomfort/ pain during period □ PMS Symptoms
□ Menopausal Symptoms □ Other _____ Any vaginal discharge? □ Yes □ No Amount _____ Color_____ Frequency _____

Men: I have: □ Prostatitis □ Impotence □ Blood/ mucous discharge from penis □premature ejaculation □ Other _____

MUSCLES, JOINTS & BONES

Do you have pain or tightness? Where? _____
The pain is (Check ALL that apply): □ Sharp □ Aching □ Numb □ Deep □ Burning
□ Dull □ Superficial pain □ Tingling □ Pain Worse / Better with heat □ Pain is Worse/ Better with cold □ Pain Worse/ Better with pressure □ Pain Worse in AM/ PM
I have (Check ALL that apply): □ Swollen joints □ Arthritis/ joint pain □ Tendonitis
□ Rheumatism □ Bone pain □ Muscle cramping □ Muscle pain □ Repetitive strain injury
□ Other _____

RESPIRATORY, EYES, EARS, NOSE & THROAT

Do you smoke? □ Yes □ No _____ (cigarettes/packs) per day, for _____years
I have: □ Frequent colds □ Chronic runny nose □ Chronic cough □ Coughing blood
□ Pain Inhaling □ Shortness of breath on exertion / at rest □ Asthma □ Nose bleeds
□ Pain / red eyes □ Poor vision □ See spots □ Dizziness □ Cold sores □ Bleeding gums
□ Dry mouth □ Frequent sore throat □ Ear pain □ Ringing in ears □ Clogged / popping ears
□ Frequent sore throat □ Cough up mucous How much? _____Color of phlegm? _____
□ Frequent headaches / migraines, describe_____ □ with nausea □ Dizziness
□ Other _____

CARDIOVASCULAR

Blood Pressure _____/_____ Have you ever been diagnosed with heart trouble? □ Yes
□ No I have: □ Chest pain □ Palpitations □ Varicose veins □ Raynaud's disease □ unusual sweating
□ Plebitis □ Cold hands & feet □ Irregular heart beat □ Poor circulation □ Other

SKIN & HAIR

I have or often have: □ Dry skin □ Skin rashes □ Itching acne □ Eczema □ Hives □ Hair loss □ Premature graying □ Other_____

SYMPTOM LIST CIRCLE what you have now UNDERLINE what you have had in the past

bronchitis – thyroid: (low, hypothyroid) or overactive (hyperthyroid) blood pressure, low or high - Blood Sugar problems: diabetes – hypoglycemia - neurocirculatory asthenia - vegetative neurosis - orthostatic dysregulation-Hashimoto's Disease-(fybroid) rheumatism - systemic lupus - erythematosus

- colitis - Crohn's disease - - atopic dermatitis rheumatic disease - rheumatic fever - arthritis - skin disease - connective tissue or ligament disease - myofascitis - tendonitis - knee ligaments - constant slight fever - pericarditis - glomerulonephritis - palmoplantar pustuli - scarlet fever - strep throat deafness tinnitus (ringing in ears) - itchy ear - ear pain - frequent ear - infections - yellow mucous - stuffy nose - post-nasal drip dry throat - itchy throat constant sinus congestion - strep throat - sore throat - dental abscess – mumps - stomatitis (inflammation of the mouth) - TMJ - toothache without cavities - anemia - feel dizzy/faint if stand up quickly or standing for a long time - easily catch cold or sore throat - swollen glands or ear infections - easily get carsick, seasick or air sick - difficult to concentrate on tasks - no appetite for breakfast - moody in morning - before noontime - no energy or feel spacey, scattered mind - energetic all evening through midnight but hate to wake up in morning taking a long shower or bath makes you feel dizzy or faint

Past Medical conditions:

Birth --- Anything significant about your birth? _____

Vaccination History Any reaction that you remember? Any unusual vaccination? _____
_____

Childhood Illnesses
Any surgery or accidents? Please list in chronological- order and indicate the length of il1ness or injury.
Age _____
_____
Age _____

Adolescent Illnesses
Any surgery or accidents? Please list in chronological order and indicate the length of illness or injury.
Age _____
Age _____
Age _____

Adulthood Illnesses
Any surgery or accidents? Please list in chronological order and indicate the length of illness or injury.
Age _____
_____
Age _____
_____
Age _____

THANK YOU! THIS INFORMATION WILL HELP ME TO BETTER SERVE YOU!