

Name _____ Date _____

What are you seeking treatment for? _____

Have you ever had acupuncture before? If so, for what condition? _____

Do you bruise or bleed easily? Yes No

Pain l r b = left, right, both

- | | | | |
|---|---|---|---|
| past current | past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> head | <input type="checkbox"/> <input type="checkbox"/> lower arm l r b | <input type="checkbox"/> <input type="checkbox"/> upper back | <input type="checkbox"/> <input type="checkbox"/> shin l r b |
| <input type="checkbox"/> <input type="checkbox"/> jaw | <input type="checkbox"/> <input type="checkbox"/> wrist l r b | <input type="checkbox"/> <input type="checkbox"/> mid-back | <input type="checkbox"/> <input type="checkbox"/> ankle l r b |
| <input type="checkbox"/> <input type="checkbox"/> neck | <input type="checkbox"/> <input type="checkbox"/> hand l r b | <input type="checkbox"/> <input type="checkbox"/> lower back | <input type="checkbox"/> <input type="checkbox"/> foot l r b |
| <input type="checkbox"/> <input type="checkbox"/> throat | <input type="checkbox"/> <input type="checkbox"/> fingers l r b | <input type="checkbox"/> <input type="checkbox"/> hip | <input type="checkbox"/> <input type="checkbox"/> heel l r b |
| <input type="checkbox"/> <input type="checkbox"/> shoulder l r b | <input type="checkbox"/> <input type="checkbox"/> chest | <input type="checkbox"/> <input type="checkbox"/> thigh l r b | <input type="checkbox"/> <input type="checkbox"/> toes l r b |
| <input type="checkbox"/> <input type="checkbox"/> upper arm l r b | <input type="checkbox"/> <input type="checkbox"/> rib/flank l r b | <input type="checkbox"/> <input type="checkbox"/> knee l r b | |
| <input type="checkbox"/> <input type="checkbox"/> elbow l r b | <input type="checkbox"/> <input type="checkbox"/> abdomen | <input type="checkbox"/> <input type="checkbox"/> calf l r b | |

Other current related symptoms _____

- | | | |
|--|---|--|
| past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> nausea | <input type="checkbox"/> <input type="checkbox"/> gas | <input type="checkbox"/> <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> <input type="checkbox"/> vomiting | <input type="checkbox"/> <input type="checkbox"/> abdominal bloating | <input type="checkbox"/> <input type="checkbox"/> constipation |
| <input type="checkbox"/> <input type="checkbox"/> belching | <input type="checkbox"/> <input type="checkbox"/> abdominal pain | <input type="checkbox"/> <input type="checkbox"/> blood in stools / black stools |
| <input type="checkbox"/> <input type="checkbox"/> heartburn | <input type="checkbox"/> <input type="checkbox"/> decreased appetite | <input type="checkbox"/> <input type="checkbox"/> pus in stools |
| <input type="checkbox"/> <input type="checkbox"/> bad breath | <input type="checkbox"/> <input type="checkbox"/> indigestion | <input type="checkbox"/> <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> <input type="checkbox"/> bleeding gums | <input type="checkbox"/> <input type="checkbox"/> low energy / fatigue | <input type="checkbox"/> <input type="checkbox"/> anal fissures |
| <input type="checkbox"/> <input type="checkbox"/> ulcers | <input type="checkbox"/> <input type="checkbox"/> crave sweets | <input type="checkbox"/> <input type="checkbox"/> rectal pain |
| <input type="checkbox"/> <input type="checkbox"/> excessive appetite | <input type="checkbox"/> <input type="checkbox"/> decreased ability to taste or smell | <input type="checkbox"/> <input type="checkbox"/> nose bleeds |
| <input type="checkbox"/> <input type="checkbox"/> change in appetite | <input type="checkbox"/> <input type="checkbox"/> sweet taste in mouth | <input type="checkbox"/> <input type="checkbox"/> recurring sore throat |
| | <input type="checkbox"/> <input type="checkbox"/> often feel pensive / thoughtful | <input type="checkbox"/> <input type="checkbox"/> difficulty swallowing |
| | <input type="checkbox"/> <input type="checkbox"/> edema | <input type="checkbox"/> <input type="checkbox"/> laryngitis / hoarse voice |

Other current related symptoms _____

- | | | |
|--|---|---|
| past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> frequent colds | <input type="checkbox"/> <input type="checkbox"/> asthma | <input type="checkbox"/> <input type="checkbox"/> dry skin |
| <input type="checkbox"/> <input type="checkbox"/> sinus infection | <input type="checkbox"/> <input type="checkbox"/> bronchitis | <input type="checkbox"/> <input type="checkbox"/> itching |
| <input type="checkbox"/> <input type="checkbox"/> cough | <input type="checkbox"/> <input type="checkbox"/> pneumonia | <input type="checkbox"/> <input type="checkbox"/> acne |
| <input type="checkbox"/> <input type="checkbox"/> cough with blood | <input type="checkbox"/> <input type="checkbox"/> chronic obstructive pulmonary disease | <input type="checkbox"/> <input type="checkbox"/> rashes |
| <input type="checkbox"/> <input type="checkbox"/> production of phlegm | <input type="checkbox"/> <input type="checkbox"/> often feel sad | <input type="checkbox"/> <input type="checkbox"/> hives |
| <input type="checkbox"/> <input type="checkbox"/> hay fever or allergies | <input type="checkbox"/> <input type="checkbox"/> crave pungent foods | <input type="checkbox"/> <input type="checkbox"/> eczema |
| | | <input type="checkbox"/> <input type="checkbox"/> psoriasis |

Other current related symptoms _____

- | | | |
|--|---|--|
| past current | past current | past current |
| <input type="checkbox"/> <input type="checkbox"/> frequent urination | <input type="checkbox"/> <input type="checkbox"/> frequent urinary tract infections | <input type="checkbox"/> <input type="checkbox"/> impotence |
| <input type="checkbox"/> <input type="checkbox"/> urgency to urinate | <input type="checkbox"/> <input type="checkbox"/> frequent vaginal infections | <input type="checkbox"/> <input type="checkbox"/> premature ejaculation |
| <input type="checkbox"/> <input type="checkbox"/> pain on urination | <input type="checkbox"/> <input type="checkbox"/> pelvic inflammatory disease | <input type="checkbox"/> <input type="checkbox"/> testicular lumps |
| <input type="checkbox"/> <input type="checkbox"/> urine / bowel incontinence | <input type="checkbox"/> <input type="checkbox"/> abnormal PAP smear | <input type="checkbox"/> <input type="checkbox"/> prostatitis |
| <input type="checkbox"/> <input type="checkbox"/> weak urine stream | <input type="checkbox"/> <input type="checkbox"/> irregular periods | |
| <input type="checkbox"/> <input type="checkbox"/> blood in urine | <input type="checkbox"/> <input type="checkbox"/> premenstrual syndrome | <input type="checkbox"/> <input type="checkbox"/> genital itching / pain |
| <input type="checkbox"/> <input type="checkbox"/> kidney stones | <input type="checkbox"/> <input type="checkbox"/> painful menstrual periods | <input type="checkbox"/> <input type="checkbox"/> genital lesions / discharges |
| <input type="checkbox"/> <input type="checkbox"/> low back pain | <input type="checkbox"/> <input type="checkbox"/> abnormal bleeding | <input type="checkbox"/> <input type="checkbox"/> decreased libido |
| <input type="checkbox"/> <input type="checkbox"/> sore / weak knees | <input type="checkbox"/> <input type="checkbox"/> menopause symptoms | |
| <input type="checkbox"/> <input type="checkbox"/> crave salty foods | <input type="checkbox"/> <input type="checkbox"/> breast lumps | <input type="checkbox"/> <input type="checkbox"/> ear ringing – low pitch |
| <input type="checkbox"/> <input type="checkbox"/> often feel afraid | | <input type="checkbox"/> <input type="checkbox"/> ear ringing – high pitch |
| | | <input type="checkbox"/> <input type="checkbox"/> decreased hearing |
| | | <input type="checkbox"/> <input type="checkbox"/> ear infections |

Name _____ Date _____

Total Pregnancies _____ Living _____ Ectopic _____ Miscarriages _____ Induced Abortions _____

Other current related symptoms _____

Family History -- Complete for each family member placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer/Tumor, Type:							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug/Alcohol Use							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Other							
Age at Death							

Allergies (ex., food, hay fever, pollen, drugs, medication, etc.) _____

past current

- dry eyes
- red eyes
- eye inflammation
- blurred vision
- poor night vision
- floaters (spots in visual field)
- visual changes
- glasses / contact lenses
- cataracts
- crave sour foods

past current

- insomnia
- excessive / vivid dreams
- grinding teeth
- depression
- anxiety / stress
- irritability
- treated for emotional / psychological problems
- indecisiveness
- often feel angry

past current

- migraine
- dizziness
- fainting
- seizures
- localized weakness
- numbness or tingling of limbs
- tremors
- poor coordination
- paralysis
- aversion to wind
- tendonitis
- gallstones

Other current related symptoms _____

past current

- high blood pressure
- low blood pressure
- palpitations
- irregular heart beat

past current

- chest pain or pressure
- jaw, neck, shoulder or arm pain
- nausea
- swollen hands or feet

past current

- blood clotting disorders
- phlebitis
- poor memory
- crave bitter foods
- usually feel happy

Other current related symptoms _____

past current

- fevers
- frequent or strong thirst
- tend to feel warmer than others
- night sweats
- sweat easily
- prefer cold food and drink

past current

- chills
- cold hands / feet
- tend to feel colder than others
- cold sweats
- prefer warm food and drink

past current

- headache
- neck stiffness
- concussion
- enlarged lymph glands

Tumors or lumps _____

Name _____ Date _____



Past or current infections _____

What is your ethnic heritage? _____

How many generations have you been in this country? _____

Please provide a list of the significant places you have lived in your life and the duration of time you lived in each place.

<u>Location</u>	<u>Date(s) In/Out or Duration of Stay</u>

Please list your family members (partners, siblings, parents, etc.) _____

Major Hospitalizations – Please list any hospitalizations or surgeries you have undergone.

<u>Year</u>	<u>Operation or Illness</u>	<u>Name of Hospital</u>	<u>City and State</u>

Medicines, Herbs and Supplements – Check any medications you are currently taking

- aspirin
- ibuprofen
- acetaminophen (Tylenol)
- oral contraceptives
- other, please list
- antacids
- fiber or other laxatives
- diet pills
- allergy medication
- blood thinners
- blood pressure pills
- insulin
- sleeping pills
- tranquilizers
- anti-depressants

Name _____ Date _____

Western Drugs

Drug	Dosage	Frequency

Herbs & Supplements

Type	Brand	Dosage	Frequency

Habits – Please check any habits which apply to you now or in the past

	Yes	No	# per day / week	Age started	Age quit
Coffee					
Other Caffeine (tea)					
Tobacco					
Marijuana					
Alcohol					
Other Drugs					

Please describe any restricted diet you follow(ed) now or in the past (ex. no red meat, vegan, vegetarian).

Please describe your typical diet.

	TIME	DESCRIPTION
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		

How many 8 oz. cups of water do you drink daily?

Name _____ Date _____

How is your dental health? (Do you have receding gums, gingivitis, etc.? Do you floss and/or use mouth wash, etc.?) When was your last visit to the dentist?

Please describe any regular program of exercise.

Do you have any religious or spiritual practice? If so, please describe.

What are the top priorities in your life?

What are your goals for your health?

Please provide any additional information about yourself or your condition not covered by the above questions.

Are you seeing other practitioners? Yes No

If yes, please provide practitioner(s) contact information and any specialties they may have.

Would it be all right to contact this/these practitioner(s) regarding your care? Yes No