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Personal Information

Patient Name: _____

Age: _____ Birth Date: _____/_____/_____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Mobile): _____

Telephone (Home): _____

Email Address: _____

Employer: _____Occupation: _____

How did you hear about us? _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____Phone: _____

Have you ever received acupuncture before? _____

Insurance Information:

_____

Insured's Name Date of Birth (DD/MM/YY) Employer

_____

Insurance Co. ID # Group #

Have you ever been diagnosed with any of the following?

☐ Diabetes	☐ Low Blood Pressure	☐ Anemia
☐ Seizures	☐ Substance addiction	☐ Arthritis
☐ Blood clots	☐ Peripheral neuropathy	☐ Fibromyalgia
☐ Stroke	☐ Ulcer/GI bleeding	☐ Depression
☐ Heart attack	☐ High Blood Pressure	☐ Anxiety
☐ Tuberculosis	☐ Asthma	☐ Cancer
☐ HIV/AIDS	☐ Hepatitis	☐ Hyper/Hypothyroidism

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Personal Medical History

Medicines (please list all medications, herbs, vitamins, and over the counter drugs)	
Allergies/Sensitivities (please list any foods, drugs, medications, or environmental factors which you are sensitive or allergic to)	
Significant Trauma (i.e. motor vehicle accidents, fractures, etc.)	
Surgeries	
Family medical history	

Other

Do you smoke? _____

If so how much/often? _____

Do you drink?_____

If so how much/often? _____

Do you use any recreational drugs?_____

If so how much/often? _____

Do you exercise? _____

If so what and how often? _____

Do you have a pacemaker? _____

Do you have a bleeding disorder? _____

Are you pregnant or could become pregnant? _____

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Chief Complaint

What health concern(s) bring you in today? _____

_____

_____

How do these affect your daily life? _____

_____

_____

Severity of symptoms on a good day: (1 is the least severe, 10 is the most severe)

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Severity of symptoms on a bad day: (1 is the least severe, 10 is the most severe)

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Severity of symptoms on average: (1 is the least severe, 10 is the most severe)

1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Have you been examined by another health care practitioner? _____

If yes, what was the diagnosis? _____

What treatment did you receive? _____

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Temperature

- ☐ Feel cold often
- ☐ Feel hot often
- ☐ Hot flashes
- ☐ Hot later in the day
- ☐ Cold hands
- ☐ Cold feet
- ☐ Cold nose

Head

- ☐ Headaches
- ☐ Migraines
- ☐ Dizzy/lightheaded
- ☐ Fainting
- ☐ Foggy head
- ☐ Sinus congestion
- ☐ Nasal discharge
- ☐ Nose bleeds
- ☐ Ear ache
- ☐ Facial pain
- ☐ TMJ pain

Skin, Hair & Nails

- ☐ Thin skin/nails
- ☐ Dry skin/nails
- ☐ Easily bruised
- ☐ Varicose veins
- ☐ Dark under eyes
- ☐ Lumps
- ☐ Red acne
- ☐ Cystic acne
- ☐ Abscesses/infection
- ☐ Premature gray hair
- ☐ Hair loss
- ☐ Dry brittle hair
- ☐ Rashes/hives
- ☐ Eczema
- ☐ Itching
- ☐ Dandruff

Perspiration/Thirst

- ☐ Sweat easily
- ☐ Night sweats
- ☐ Excessive sweating
- ☐ Does not sweat
- ☐ Thirsty for cold
- ☐ Thirsty for warm
- ☐ No thirst

Senses

- ☐ Declining vision
- ☐ Sensitive to light
- ☐ Red/itchy eyes
- ☐ Floaters in eyes
- ☐ Poor hearing
- ☐ Taste/smell problem
- ☐ Eye strain/pain
- ☐ Ear ringing
- ☐ Night blindness
- ☐ Blurry vision

Lungs & Heart

- ☐ Wheezing
- ☐ Coughing
- ☐ Phlegm
- ☐ Cough blood
- ☐ Painful breathing
- ☐ Difficult breathing
- ☐ Short of breath
- ☐ Chest tightness
- ☐ Frequent colds
- ☐ Seasonal allergies
- ☐ Slow heart rate
- ☐ Fast heart rate
- ☐ Irregular heart beat
- ☐ Palpitations
- ☐ Chest pain

Energy

- ☐ Nervous Energy
- ☐ Good energy
- ☐ Low energy
- ☐ High energy/hyper
- ☐ Fidgety

Mouth

- ☐ Frequent sore throat
- ☐ Poor teeth
- ☐ Mouth/canker sores
- ☐ Lip sores
- ☐ Dry/chapped lips
- ☐ Toothache

Cravings

- ☐ Sweet
- ☐ Salty
- ☐ Sour
- ☐ Bitter
- ☐ Hot/Spicy
- ☐ Bland
- ☐ Carbohydrates
- ☐ Other_____

Appetite & Digestion

- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Food sensitivities
- ☐ Excessive saliva
- ☐ Heartburn/reflux
- ☐ Chronic laxative use
- ☐ Indigestion
- ☐ Nausea/vomiting
- ☐ Gas
- ☐ Tired after eating
- ☐ Bloated after eating
- ☐ Bad breath
- ☐ Abdominal pain
- ☐ Belching/hiccups
- ☐ Gall stones
- ☐ Pain under ribs

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Sleep

- ☐ Insomnia
- ☐ Excessive sleep
- ☐ Difficult to fall asleep
- ☐ Wake during night
- ☐ Vivid Dreams
- ☐ Disturbing dreams
- ☐ Wake unrested
- ☐ # of hours _____

Bowel Movements

- ☐ Constipation
- ☐ Loose stool
- ☐ Urgent BM in AM
- ☐ Cramps with BM
- ☐ Burning with BM
- ☐ Incomplete BM
- ☐ Hemorrhoids
- ☐ Bowel incontinence
- ☐ Blood/mucus in stool
- ☐ Foul odor
- ☐ Alternating constipation and diarrhea

Urination

- ☐ Dark urine
- ☐ Cloudy urine
- ☐ Burning urine
- ☐ Painful urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Incontinence
- ☐ Frequent urination
- ☐ Wake to urinate
- ☐ Frequent UTIs
- ☐ Kidney stones
- ☐ STD

Mental & Emotional

- ☐ Poor memory
- ☐ Poor concentration
- ☐ Irritability/anger
- ☐ Tense/overwhelmed
- ☐ Sad
- ☐ Tearful/weepy
- ☐ Restless/fidgety
- ☐ Anxious/worried
- ☐ Can't stop thinking
- ☐ Easily startled
- ☐ Manic
- ☐ Depressed
- ☐ Frequent sighing
- ☐ Frequent yawning
- ☐ Seizures
- ☐ Twitches/tremors
- ☐ Nasal discharge
- ☐ Lack coordination
- ☐ Loss of balance
- ☐ Concussion
- ☐ Mood swings

Musculoskeletal

- ☐ All over body pain
- ☐ Muscle tightness
- ☐ Knees feel cold
- ☐ Back feels cold
- ☐ Sore back/knees
- ☐ Limbs feel heavy
- ☐ Numb hands/feet
- ☐ Swelling/edema
- ☐ Body heaviness

Diet & Lifestyle

- ☐ Vegan/vegetarian
- ☐ Poor diet
- ☐ Gain weight easily
- ☐ Overweight
- ☐ Drink caffeine
- ☐ Smoke cigarettes
- ☐ Chew tobacco
- ☐ Drink alcohol
- ☐ Use drugs
- ☐ Eating disorder
- ☐ Exercise a lot
- ☐ Don't exercise
- ☐ Job stress
- ☐ Family stress
- ☐ Other stress

Men's Health

- ☐ Impotence
- ☐ Erectile dysfunction
- ☐ Testicular pain
- ☐ Testicular swelling
- ☐ Cold genitalia
- ☐ Numb genitalia
- ☐ Premature ejaculation

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Women's Health History

General Gynecology

- ☐ High sexual energy
- ☐ Low libido
- ☐ Chronic vaginal discharge
- ☐ Frequent yeast infections
- ☐ Vaginal dryness
- ☐ Breast lumps
- ☐ Nipple pain/discharge
- ☐ Mastitis
- ☐ Cysts
- ☐ Endometriosis
- ☐ Fibroids
- ☐ PID
- ☐ Abnormal pap smear
- ☐ Uterine or bladder prolapse

Age when menses began _____

Length of cycle _____

Length of Flow_____

Flow is:☐Light ☐Moderate ☐Heavy

Do you have spotting? _____

Method of birth control _____

Trying to conceive? _____

Currently lactating? _____

Number of pregnancies _____

Number of children _____

Number of miscarriages _____

Number of abortions _____

High-risk pregnancies? _____

Difficult labor/deliveries? _____

Postpartum concerns? _____

Peri-menopausal? _____

Post-menopausal? _____

Ovulation

- ☐ Increase in cervical mucus
- ☐ Cramping
- ☐ Spotting
- ☐ Breast tenderness

Symptoms around period

- ☐ Fatigue
- ☐ Light-headed
- ☐ Headache
- ☐ Loose stools
- ☐ Breast tenderness
- ☐ Mood changes
- ☐ Acne
- ☐ Retain water

Color of menstrual blood

- ☐ Red
- ☐ Thin and watery
- ☐ Pinkish
- ☐ Brownish or black
- ☐ Blood with stringy mucus

Menstrual cramps are:

- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Better with heat
- ☐ Stabbing or piercing
- ☐ Cramping, colicky
- ☐ Better after passing clots
- ☐ Down bearing sensation

Location of cramps:

- ☐ Low back
- ☐ Low abdomen
- ☐ External genitalia

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