

Patient Chief Complaint or Health Issue

Please describe your main health issue or complaint which has resulted in you seeking acupuncture treatments (be as specific as possible):

Types of Pain

Please describe location of aches and pains (if applicable):

Pain Characteristics

Please check all that apply.

- | | | | | | | | |
|----------|--------------------------|----------|--------------------------|----------|--------------------------|-------------|--------------------------|
| Dull | <input type="checkbox"/> | Sharp | <input type="checkbox"/> | Stabbing | <input type="checkbox"/> | Severe | <input type="checkbox"/> |
| Moderate | <input type="checkbox"/> | Sore | <input type="checkbox"/> | Cramping | <input type="checkbox"/> | Throbbing | <input type="checkbox"/> |
| Burning | <input type="checkbox"/> | Radiates | <input type="checkbox"/> | Fixed | <input type="checkbox"/> | Moves About | <input type="checkbox"/> |

Pain radiates to: _____

Describe the onset of the pain: _____

Pain is relieved by: _____

Pain is worsened with: _____

Are there any movements that aggravate the pain? _____

How does exercise affect your pain? _____

Do any medications help alleviate the pain? If so, please list: _____

Other treatment you have had for the pain? _____

Patient Diagnostic Test Results

Please answer as completely and accurately as possible.

	<u>Date</u>	<u>Results</u>
Blood Work		
X-Rays		
MRI		
CT Scan		
EMG		

Please list any surgeries that you have had. If so, when and where on the body was surgery performed? Continue on reverse if necessary.

Patient and Relative Health History

Please indicate which illness/disease you or your blood relatives have experienced:

**Blood relatives constitute your Grandparents, Parent, Siblings and Children.*

Illness/Disease	Who	Approximate Date
Anemia		
Appendicitis		
Cancer		
Diabetes		
Emotional Disorders		
Heart Disease		
Hepatitis		
High Blood Pressure		
Infectious Disease		
Rheumatic Fever		
Seizures		
Tuberculosis		

Do you currently or have you ever had a sexually transmitted disease?

Please circle those that apply and include approximate date contracted:

AIDS/HIV Chlamydia Gonorrhea Herpes HPV Syphilis

Patient Medication and Supplement Record

Please check all that apply.

- | | | | | | |
|-------------------|--------------------------|--------------------|--------------------------|-----------------------------------|--------------------------|
| Antacids | <input type="checkbox"/> | Tylenol or Advil | <input type="checkbox"/> | Oral Contraceptives | <input type="checkbox"/> |
| Antidepressants | <input type="checkbox"/> | Laxatives | <input type="checkbox"/> | Chemotherapy or Radiation Therapy | <input type="checkbox"/> |
| Antibiotics | <input type="checkbox"/> | Daily Vitamins | <input type="checkbox"/> | Glucose or Insulin | <input type="checkbox"/> |
| Antifungals | <input type="checkbox"/> | Heart medications | <input type="checkbox"/> | Relaxants or Regulators | <input type="checkbox"/> |
| Anti-Inflammatory | <input type="checkbox"/> | Thyroid Medication | <input type="checkbox"/> | Blood Pressure Medications | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | Sleeping pills | <input type="checkbox"/> | Recreational or Illegal Drugs | <input type="checkbox"/> |

Please list any medications and/or supplements you are currently taking:

Type/Name	Dosage	Reason	Prescribed Date/OTC

**continue on reverse if necessary*

Other(s) discontinued within the past three (3) months:

**continue on reverse if necessary*

Patient Dietary Routine

Please be as specific as possible, by listing the typical intake of foods and dietary supplements.

<u>Breakfast</u>	
<u>Lunch</u>	
<u>Dinner</u>	
<u>Snacks</u>	
<u>Supplements</u>	

Patient Patterns of Health and Symptoms

Please indicate which of the following symptoms you experience and there frequency. Check or circle only those that apply.

Pattern A:		Pattern B:			
<u>Symptom Type</u>	Often Usually	Occasionally Sometimes	<u>Symptom Type</u>	Often Usually	Occasionally Sometimes
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Drooping eyelid(s)	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Prolapsed uterus	Y	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Prolapsed stomach	Y	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness of voice	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Vocal problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	Excess Gas/Flatulence	<input type="checkbox"/>	<input type="checkbox"/>
Nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Belching/Burping	<input type="checkbox"/>	<input type="checkbox"/>
Itching eyes	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Sinus headache	<input type="checkbox"/>	<input type="checkbox"/>	"Butterfly" sensation in stomach	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal rumbling	<input type="checkbox"/>	<input type="checkbox"/>
Perspire easily	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue after eating	<input type="checkbox"/>	<input type="checkbox"/>
Itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	Discomfort after eating	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	Y	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	Y	
Painful Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Slow wound healing	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	Craves sweets	<input type="checkbox"/>	<input type="checkbox"/>
Dry/brittle hair	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Fatigued after perspiring	<input type="checkbox"/>	<input type="checkbox"/>	Poor short-term memory	<input type="checkbox"/>	<input type="checkbox"/>
Catches cold easily	<input type="checkbox"/>	<input type="checkbox"/>	Poor long-term memory	<input type="checkbox"/>	<input type="checkbox"/>
Grieving over lost ones	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Melancholy or Sadness	<input type="checkbox"/>	<input type="checkbox"/>			
Crave spicy foods	<input type="checkbox"/>	<input type="checkbox"/>			
Dislikes dry weather	<input type="checkbox"/>	<input type="checkbox"/>			
Dislikes wind	<input type="checkbox"/>	<input type="checkbox"/>			
Dislikes damp weather	<input type="checkbox"/>	<input type="checkbox"/>			

Please list any known allergies and/or sensitivities:

Patient Patterns of Health and Symptoms: *Continued*

Please indicate which of the following symptoms you experience and there frequency. Check or circle only those that apply.

Pattern C:

<u>Symptom Type</u>	Often Usually	Occasionally Sometimes
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>
Sore eyes	<input type="checkbox"/>	<input type="checkbox"/>
Red eyes	<input type="checkbox"/>	<input type="checkbox"/>
Yellow eyes	<input type="checkbox"/>	<input type="checkbox"/>
Yellow skin	<input type="checkbox"/>	<input type="checkbox"/>
Tight/constricted chest	<input type="checkbox"/>	<input type="checkbox"/>
Hiccough/hiccups	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>
Rib-side pain	<input type="checkbox"/>	<input type="checkbox"/>
Angered easily	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Depressed	<input type="checkbox"/>	<input type="checkbox"/>
Frustrated	<input type="checkbox"/>	<input type="checkbox"/>
Clear throat often	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of something in throat	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
High triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
History of hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Pains increased with stress	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Last reading:	s# _____	
	d# _____	
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Where on your head?		
Top	Front	Sides
	Back	Behind
	Eyes	

Pattern D:

<u>Symptom Type</u>	Often Usually	Occasionally Sometimes	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Slump time of day:	_____		
Awakens fatigued	<input type="checkbox"/>	<input type="checkbox"/>	
Cold feet	<input type="checkbox"/>	<input type="checkbox"/>	
Cold hands	<input type="checkbox"/>	<input type="checkbox"/>	
Intolerant of cold	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	
Number of times daily:	_____		
Night urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgent urination	<input type="checkbox"/>	<input type="checkbox"/>	
Dribbling urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Urine color	Dark	Light	Clear
Decreased stream or amount	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Urinary Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete Urination	<input type="checkbox"/>	<input type="checkbox"/>	
Impotence	<input type="checkbox"/>	<input type="checkbox"/>	
Premature Ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	
Seminal Emission	<input type="checkbox"/>	<input type="checkbox"/>	
Sex Drive	High	Low	Normal
Infertility	Y	N	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Pitch:	High	Low	
Length:	Constant	Intermittent	
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	
Tooth loss	<input type="checkbox"/>	<input type="checkbox"/>	
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>	
Stiff joints	<input type="checkbox"/>	<input type="checkbox"/>	
Painful joints	<input type="checkbox"/>	<input type="checkbox"/>	
Pains get worse with exercise	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Fears/Phobias	Y	N	
If so, please list:	_____		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Puffy beneath eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Dark circles beneath eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Morning diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	

Patient Patterns of Health and Symptoms: *Continued*

Please indicate which of the following symptoms you experience and there frequency. Check or circle only those that apply.

Pattern E:

<u>Symptom Type</u>	Often Usually	Occasionally Sometimes
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Racing heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Missing pulse beats	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Chest congested	<input type="checkbox"/>	<input type="checkbox"/>
Delirium	<input type="checkbox"/>	<input type="checkbox"/>
Jittery	<input type="checkbox"/>	<input type="checkbox"/>
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Dream-disturbed sleep	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Tongue sores	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>
Flushing in afternoon	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>	<input type="checkbox"/>
Numb skin	<input type="checkbox"/>	<input type="checkbox"/>
Scanty, yellow urine	<input type="checkbox"/>	<input type="checkbox"/>

Pattern F:

<u>Symptom Type</u>	Often Usually	Occasionally Sometimes
Sense of heaviness	<input type="checkbox"/>	<input type="checkbox"/>
Favors warm drinks	<input type="checkbox"/>	<input type="checkbox"/>
Physical labor	<input type="checkbox"/>	<input type="checkbox"/>
Sedentary work	<input type="checkbox"/>	<input type="checkbox"/>
Regular exercise	<input type="checkbox"/>	<input type="checkbox"/>
Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>
Twitches/spasms	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fever/chills	<input type="checkbox"/>	<input type="checkbox"/>
History of Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
History of Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>

Pattern G: Females Only

<u>Symptom Type</u>	Often Usually	Occasionally Sometimes	
Age at first period	_____		
Age of menopause	_____		
Painful menses	<input type="checkbox"/>	<input type="checkbox"/>	
Average duration of cycle (i.e.28 days))	_____		
Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>	
Average duration of flow (i.e. 4-7)	_____		
Blood clots visible	<input type="checkbox"/>	<input type="checkbox"/>	
Cramps	Before	During	After
Color of flow	Dark	Light	Bright
Breast distention	<input type="checkbox"/>	<input type="checkbox"/>	
Breast pain			
Date of last period	_____		
Recent change in period	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>	
Fibroid tumors	<input type="checkbox"/>	<input type="checkbox"/>	
Fibrocystic breast(s) or ovary(ies)	<input type="checkbox"/>	<input type="checkbox"/>	
Date of last Pap exam	_____		
History of irregular pap exams	<input type="checkbox"/>	<input type="checkbox"/>	
Number of pregnancies	_____		
Miscarriages	Y _____		
If so, number	Y _____		
Infertility	Y _____		

Have you had any Gynecological surgeries?
Please list procedures and approximate dates:

Have you experienced any other premenstrual symptoms?
Please list:
