

<p>On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____</p> <p>Have you had acupuncture before? _____</p> <p>If yes, where/who _____</p> <p>Any concerns or fears about the needles? _____</p> <p>If yes, what? _____</p> <p>What are your goals of your acupuncture visits?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>MEDICAL CONDITIONS</p> <p>Please List conditions & surgeries you have had and year diagnosed.</p>		<p>ALLERGIES</p> <p>Medications, Seasonal, Environmental, Food.</p>

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SYMPTOMS – ****NOTE**:** For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.

<p>LIVER / GALLBLADDER</p> <p>_____ Irritability / Anger</p> <p>_____ Depression / Stress</p> <p>_____ Headaches / Migraines</p> <p>_____ Visual Problems</p> <p>_____ Red / Dry / Itchy Eyes</p> <p>_____ Gall Stones</p> <p>_____ Dizziness</p> <p>_____ Blurred Vision</p> <p>_____ Feeling of Lump in Throat</p> <p>_____ Clenching of Teeth at Night</p> <p>_____ Muscle Cramping / Twitching</p> <p>_____ Tension</p> <p>_____ Joints/Neck/Shoulder Pain/Tight</p> <p>_____ Poor Circulation</p> <p>_____ Soft / Brittle Nails</p> <p>_____ Emotional Eater</p> <p>KIDNEY / URINARY BLADDER</p> <p>_____ Urinary Problems</p> <p>_____ Bladder Infection</p> <p>_____ Lack of Bladder Control</p> <p>_____ Weakness / Pain in Lower Back</p> <p>_____ Decrease Bone Density</p> <p>_____ Feel Cold Easily</p> <p>_____ Low Sex Drive</p> <p>_____ Excess Sexual Desire</p> <p>_____ Poor Memory</p> <p>_____ Loss of Hair</p> <p>_____ Hearing Problems</p> <p>_____ Cavities</p> <p>_____ Craving / Avoiding Salty Foods</p> <p>_____ Fear</p> <p>_____ Hot Flush / Night Sweating</p>	<p>HEART / SMALL INTESTINES</p> <p>_____ Heart Palpitations</p> <p>_____ Chest Pain</p> <p>_____ Insomnia / Sleep Problems</p> <p>_____ Easily Startled</p> <p>_____ Restlessness / Agitation</p> <p>_____ Vivid Dreams</p> <p>_____ Lack of Joy in Life</p> <p>LUNG / LARGE INTESTINE</p> <p>_____ Dry Cough</p> <p>_____ Cough with Sputum</p> <p>_____ Nasal Discharge</p> <p>_____ Post-Nasal Drip</p> <p>_____ Sinus Infection / Congestion</p> <p>_____ Itchy, Red or Painful Throat</p> <p>_____ Dry Mouth / Throat / Nose</p> <p>_____ Skin Rashes / Hives</p> <p>_____ Snoring</p> <p>_____ Grief / Sadness</p> <p>_____ Shortness of Breath</p> <p>_____ Allergies / Asthma</p> <p>_____ Low Resistance to Colds or Flu</p> <p>_____ Sneezing</p> <p>_____ Mild Fever Comes & Goes</p> <p>_____ Smoke Cigarettes</p>	<p>SPLEEN / STOMACH</p> <p>_____ Heaviness Anywhere in Body</p> <p>_____ Fatigue / Worse After Eating</p> <p>_____ Hard to Get Up in the Morning</p> <p>_____ Edema (Swelling)</p> <p>_____ Muscles Feel Tired Often</p> <p>_____ Easily Bruising & Bleeding</p> <p>_____ Bad Breath</p> <p>_____ Decreased / Increased Appetite</p> <p>_____ Crave Sweets</p> <p>_____ Hypoglycemia</p> <p>_____ Difficulty Digesting Oily Foods</p> <p>_____ Nausea / Vomiting</p> <p>_____ Gas / Belching</p> <p>_____ Insulin Sensitivity</p> <p>_____ Hemorrhoids</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Abdominal Pain</p> <p>_____ Indigestion / Heartburn</p> <p>_____ Over-Thinking</p> <p>_____ Tendency to Gain Weight</p> <p>_____ Brain Foggy</p>
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PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a “C” under the appropriate person’s column. “P” should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

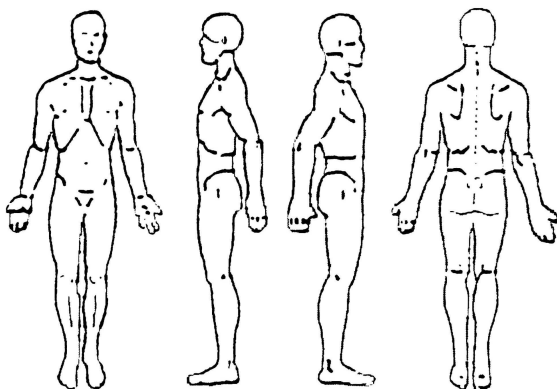
	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
<i>Age</i>							
AIDS / HIV							
Alcohol							
Anxiety							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
Headaches							
Heart Trouble							
Hepatitis							
High Blood Pressure							
Immune Disorder							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Neck Pain							
Thyroid Disorder							
Tobacco							
Weight Problem							
Other Emotional Problems: _____							
Other: _____							

If any of the above family members are deceased, please list their age at death and cause.

MUSCULOSKELETAL

- Muscle Cramps – Where? Muscle Pain / Rheumatism – Where? Arthritis – Where?
- Joint Swelling – Where? Tendonitis – Where? Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

- Sharp Burning Aching
- Fixed Other: _____

- Sharp Burning Aching
- Fixed Other: _____

- Sharp Burning Aching
- Fixed Other: _____

Women Only

Hysterectomy – Ovaries Removed? Yes No

Could You be Pregnant Now? Yes No

Number Of: _____ Pregnancies _____ Miscarriages
 _____ Births _____ Abortions

Post-menopausal Bleeding Yes No

When did your last period end? _____

Number of days for monthly cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:

Heavy Moderate Light None

Color of Menstrual Flow:

Dark Bright Red Slightly Reddish

Birth Control:

None IUD Birth Control Pills

Spermicides Barriers

Do You Suffer From:

Cramping (*Mark as appropriate*)
 Severe Moderate
 Mild Before Period
 During Period After Period

Clotting (*Mark as appropriate*)
 Bright in Color Dark in Color

Bleeding Between Periods Infertility
 Pelvic Inflamm. Disease Ovarian Cysts
 Endometriosis Hot Flashes
 Mastitis Breast Cysts
 Yeast Infection / Vaginitis / Other Discharge

Premenstrual Syndrome (*Mark as appropriate*)
 Fluid Retention Cravings
 Fluctuating Emotions Irritability
 Tenderness in Breasts Depression
 Fatigue

Men Only

Impotence Weak Erection
 Discharge from Penis Prostate Problems
 Testicular Pain or Lump Infertility
 Premature Ejaculation Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!