Acupuncture Center

Medical History

Date: _____

Name:_____ Date of Birth:_____

Street:_____

City_____ State:_____ ZIP:_____

Phone (H):_____ (C):_____ (W): _____

Sex: F( ) M( ) Height: _____Weight:_____ Number of Children:_____

Married ( ) Single ( ) Widowed ( ) Divorced ( ) Separated ( ) Other ( )

Occupation:_____

Who referred you to this office? _____

Have you had an acupuncture treatment before?_____

Purpose of this appointment:_____

Present symptoms:_____

_____

Other areas of pain or concern:_____

_____

Health professionals seen for this condition:_____

_____

Has there been a medical diagnosis? Yes ( ) No ( ) If Yes what?_____

_____

How, When, and Where did this condition begin?_____

_____

_____

Does this condition impair your daily activities, work, or sleep?_____

Is condition progressively worse, constant, or comes and goes?_____

Does anything provide relief?_____

_____

List all major accidents, surgeries, scars, hospitalizations:_____

_____

_____

List all medications/supplements you currently take:_____

_____

_____

Tobacco use?? Yes ( ) No ( ). What, how much?_____

Do you drink caffeine? Yes ( ) No ( ) What, and how many cups per day? _____

Do you drink alcohol? Yes ( ) No ( ) If yes, how many drinks per week? _____

Level of daily stress: 1 (least) _____1O (most).

Do weather conditions affect your condition? Yes ( ) No ( ).

How many hours per week do you work? _____

What are the main stress factors in your life?_____

_____

What are the main ways you relax and reduce stress? _____

_____

What types of exercise do you presently participate in? _____

_____

Please describe your health and any other additional comments: _____

_____

_____

_____

Name: _____

If you have ever had any of the symptoms below, write "**P**" if they occurred in the past, "**C**" if current, and "**I**" if they are intermittent.

HEAD

_____headaches
_____dizziness
_____fainting
_____loss of balance
_____eyes watering
_____sensitive to light
_____dry eyes
_____spots in eyes
_____eye pain or itch
_____glaucoma
_____cataracts
_____trouble with vision
_____hearing problems
_____noise/ringing in ears
_____earaches or drainage
_____ear infections
_____dental problems
_____loss of any teeth
_____teeth hurt
_____teeth feel loose
_____grinding teeth
_____bad breath
_____jaw clicks
_____facial pain
_____facial tics
_____sore or bleeding gums
_____sore tongue
_____lack of sense of taste
_____mouth sores
_____difficulty swallowing
_____lump in throat
_____sore throat
_____dry mouth
_____excess salivation
_____sneezing spells
_____sinus problems
_____stuffy or runny nose
_____frequent head colds
_____hoarse voice
_____nasal polyps
_____nosebleeds

CHEST

_____shortness of breath
_____wheezing or gasping
_____dry cough
_____cough with sputum
_____cough up blood
_____chest colds
_____heart murmur
_____rapid heartbeat
_____heart "skips beats"
_____palpitations or pounding
_____chest pain/pressure
_____stuffy sensation in chest
_____difficulty breathing when lying down
_____asthma
_____rib or flank pain
_____pneumonia

GASTORINTESTINAL

_____food sits in stomach
_____anemia
_____food cravings
_____gnawing hunger
_____frequent thirst
_____thirsty, but can't drink
_____loss of appetite
_____weight gain/loss
_____recurring indigestion
_____heartburn
_____stomach ache
_____acid reflux
_____nausea or vomiting
_____belching
_____bitter taste in mouth
_____sweet taste in mouth
_____flatulence
_____intestinal gurgling
_____bloating
_____abdominal pain
_____anal prolapse
_____constipation
_____diarrhea or loose stool
_____fecal incontinence
_____hard dry stool
_____straining at stool
_____use of laxatives
_____black stools
_____clay-colored stools
_____rectal pain or itch
_____hemorrhoids
_____blood or pus w/stools

UROGENITAL

_____pain during intercourse
_____frequent urination
_____involuntary loss of urine
_____up at night to urinate
_____burning on urination
_____cloudy urine
_____weakened urine stream
_____brown or reddish urine
_____urine flow is slow to start
_____frequent urge to urinate
_____kidney stone
_____bladder infection
_____kidney infection
_____genital herpes
_____venereal disease
_____change in sexual energy
_____infertility

SLEEP

_____awaken fatigued
_____excess sleeping
_____insomnia
_____dream-disturbed sleep
_____nightmares
_____very vivid dreams
_____repetitive dreams
_____light sleeper

SLEEP (cont.)
_____other sleep problem
_____hard to fall asleep

SWEATING
_____sweaty palms/feet
_____night sweating
_____sweats easily
_____cold sweats
_____lack of perspiration
_____other unusual sweating

HOT/COLD
_____hot palms/feet/chest
_____intolerance of heat/cold
_____feel hot
_____hot face
_____feel cold
_____cold back
_____cold hands/feet
_____cold abdomen
_____fevers /chills

BONE, MUSCLE, NERVE
_____numbness/tingling
_____low back sore or weak
_____neck pain
_____disk problems
_____gout
_____arthritis
_____upper/mid-back pain
_____shoulder pain
_____hip/knee/ankle pain
_____low back pain
_____osteoporosis
_____whiplash
_____other spinal problems
_____broken bones
_____muscle tension
_____joint swelling & pain
_____joints make noise
_____leg cramps
_____muscle ache
_____trembling or tremors

CARDIOVASCULAR
_____high blood pressure
_____low blood pressure
_____swelling in hands/feet
_____phlebitis
_____vascular spiders
_____Raynaud's disease
_____cellulitis
_____varicose veins

SKIN, HAIR, NAILS
_____shingles
_____weak fingernail
_____hair loss
_____eczema/psoriasis
_____change in skin/hair
_____rashes
_____warts/growths
_____painful scars
_____fungus infections
_____pimples or boils
_____infections
_____ulcerations or sores
_____bruise easily
_____dry skin

MENTAL
_____poor concentration
_____disorientation
_____unusual fears
_____emotional disorder
_____poor memory
_____work/family problems
_____nervous/anxiety
_____fatigue
_____bad temper
_____depression
_____repeated thoughts
_____easily stressed
_____worry a lot
_____decisions difficult

OTHER
_____pleurisy
_____cancer
_____heart disease
_____tuberculosis
_____pacemaker
_____CVA (stroke)
_____paralysis
_____Rheumatic fever
_____mononucleosis
_____thyroid disorder
_____diabetes
_____epilepsy
_____Meniere's disease
_____hepatitis-year
_____polio
_____HIV+
_____emphysema

MEN ONLY
_____loss of erection/impotence
_____testicular pain
_____penis pain
_____genital itch
_____hernia
_____nocturnal emissions
_____prostate problem
_____loss of semen during day

WOMEN ONLY
_____menstrual pain
_____irregular menses
_____loss of menses
_____change in menstrual flow
_____PID
_____hot flashes
_____abortions
_____miscarriages
_____vaginal yeast
_____fibroids, ovarian cyst
_____endometriosis
_____clotted blood in menses
_____late/early period
_____premenstrual moodiness
_____uterine bleeding
_____vaginal discharge
_____vaginal itch
_____abnormal PAP test
_____lower abdominal pain
_____breast pain/tenderness
_____water retention
_____breast lumps
_____breast discharge

WOMEN ONLY(this section)

Are you pregnant? Yes ( ) No ( )

If Yes, name and telephone number of physician midwife: _____

Have you experienced menopause? Yes ( ) No ( )

Have you had a hysterectomy? Yes ( ) No ( )

Are you prone to vaginal infections? Yes ( ) No ( )

Is your period irregular? Yes ( ) No ( )

Are you tired and/or feel depleted after your period? Yes ( ) No( )

Do you have PMS? Yes ( ) No( )

Date of last period: _____/_____/_____

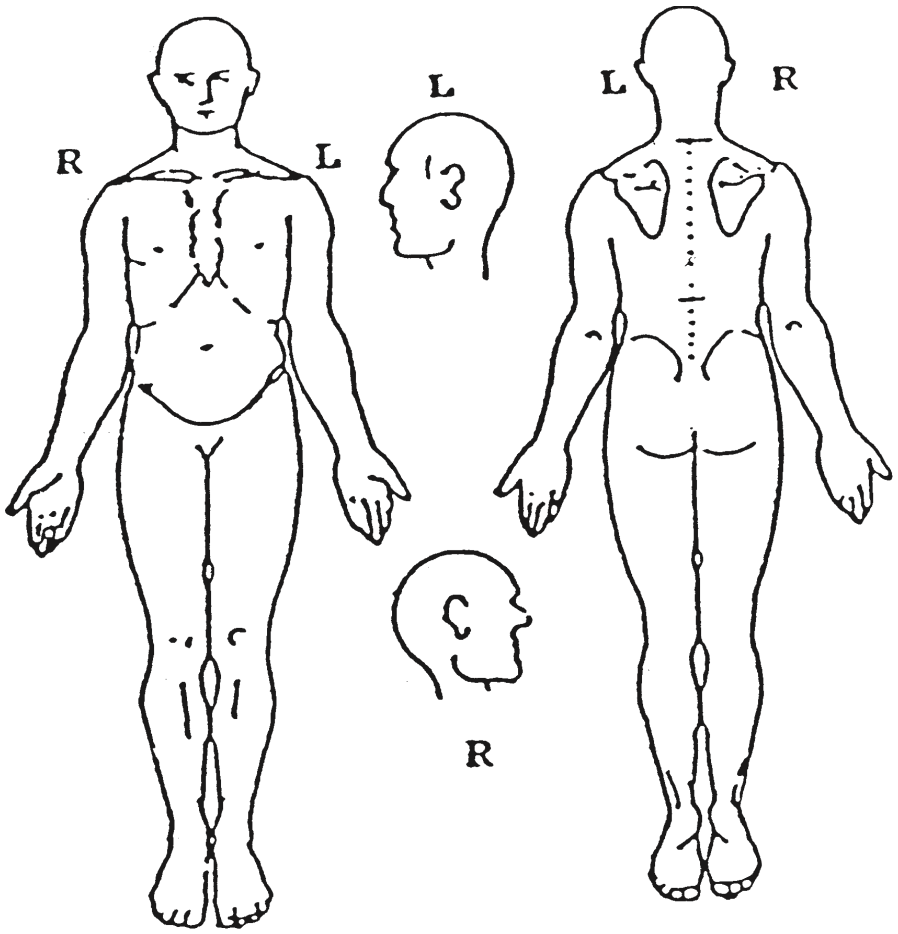
The usual interval between periods? _____days

How long does your period last? _____ days

Is your flow: Heavy ( ) Moderate ( ) Light ( )

What color best describes your flow? _____

ALL CONTINUE. Please mark or color in all areas of pain or discomfort.



Do you have any disease, condition, or problem not listed above? Yes ( ) No ( )

If yes, please list: _____

_____

_____

_____

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acucenz.com

Patient Data Worksheet

Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone (h):_____ (c):_____ (w):_____

Email:_____

Please circle your preferred mode of contact above for reminders.

Referral source: Name:_____

Address:_____

In case of an Emergency, please contact:

Name:_____

Phone:_____

* The use of moxabustion in conjunction with your acupuncture treatment may cause a blister at the acupuncture point. You may refuse this or any part of the treatment.
* Our office policy requires payment on the day of your visit.
* Kindly allow 24-hour minimum notice for change or cancellation of appointment. No shows will owe a fee of $25.00. We absolutely forgive emergencies.
* There will be a $30.00 fee for returned checks.

. . . . . .

I, the undersigned, have read and understand the above policies:

_____

Signature Date