

NEW ACUPUNCTURE PATIENT HISTORY FORM

All acupuncture patients must also complete Clinic "Application for Treatment" form.

Name: _____ Today's Date: ____/____/____
Date of Birth: ____/____/____ Height: _____ Weight: _____ B.P. _____
Emergency Contact: Name: _____ Phone: _____

Reason for today's visit: _____

Have you had acupuncture before? Yes _____ No _____

Have you had Chinese herbal medicine before? Yes _____ No _____

How long have you had this condition? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

What activities are restricted by it? _____

Are you under the care of a physician now? Yes _____ No _____

If yes, for what condition(s)? _____

Who is your physician? _____ Dr.'s phone _____

Family Medical History: Have any blood relatives had:

ALLERGIES

ARTERIOSCLEROSIS

ALCOHOLISM

CANCER

DIABETES

HEART DISEASE

HIGH BLOOD PRESSURE

SEIZURES

STROKE

Your past medical History: Have you ever had:

__ AIDS/HIV

__ ALCOHOLISM

__ ALLERGIES

__ APPENDICITIS

__ ARTERIOSCLEROSIS

__ ASTHMA

__ BIRTH TRAUMA (YOUR BIRTH)

__ CANCER

__ CHICKEN POX

__ DIABETES

__ EMPHYSEMA

__ EPILEPSY

__ GOITER

__ GOUT

__ HEART DISEASE

__ HEPATITIS

__ HERPES

__ HIGH BLOOD

PRESSURE

__ MEASLES

__ MULTIPLE

SCLEROSIS

__ MUMPS

__ PACEMAKER

__ PLEURISY

__ PNEUMONIA

__ POLIO

__ RHEUMATIC FEVER

__ SCARLET FEVER

__ SEIZURES

__ STROKE

__ SURGERY

__ THYROID

DISORDERS

__ MAJOR TRAUMA

__ TUBERCULOSIS

__ TYPHOID FEVER

__ ULCERS

__ VENEREAL

DISEASE

__ WHOOPING COUGH

OTHER (SPECIFY)

Your Diet:

Appetite: Low High

Do You Use: Coffee Soda Sugar Salty Snacks Artificial Sweeteners

Typical Daily Menu:

Morning	Snack	Noon	Snack	Evening	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmaceuticals taken in last 2 months:

Vitamins/supplements taken in the last 2 months:

Lifestyle:

alcohol marijuana stress occupational hazards Exercise: yes no frequency: _____
 tobacco drugs _____ type: _____

General Symptoms:

<input type="checkbox"/> poor appetite	<input type="checkbox"/> recent weight loss/gain	<input type="checkbox"/> fatigue	<input type="checkbox"/> fever	<input type="checkbox"/> bleed or bruise easily
<input type="checkbox"/> heavy appetite	<input type="checkbox"/> poor sleep	<input type="checkbox"/> lack of strength	<input type="checkbox"/> chills	<input type="checkbox"/> peculiar taste (describe)
<input type="checkbox"/> strongly like cold drinks	<input type="checkbox"/> heavy sleep	<input type="checkbox"/> bodily heaviness	<input type="checkbox"/> night sweats	_____
<input type="checkbox"/> strongly like hot drinks	<input type="checkbox"/> dream-disturbed sleep	<input type="checkbox"/> cold hands or feet	<input type="checkbox"/> sweat easily	_____
		<input type="checkbox"/> poor circulation	<input type="checkbox"/> muscle cramps	_____
		<input type="checkbox"/> shortness of breath	<input type="checkbox"/> vertigo or dizziness	_____

Head, Eyes, Ears, Nose, Throat

<input type="checkbox"/> glasses	<input type="checkbox"/> night blindness	<input type="checkbox"/> sores on lips or tongue	<input type="checkbox"/> recurrent sore throat	<input type="checkbox"/> earaches
<input type="checkbox"/> eye strain	<input type="checkbox"/> glaucoma	<input type="checkbox"/> dry mouth	<input type="checkbox"/> swollen glands	<input type="checkbox"/> headaches
<input type="checkbox"/> eye pain	<input type="checkbox"/> cataracts	<input type="checkbox"/> excessive saliva	<input type="checkbox"/> lumps in throat	<input type="checkbox"/> migraines
<input type="checkbox"/> red eyes	<input type="checkbox"/> teeth problems	<input type="checkbox"/> sinus problems	<input type="checkbox"/> enlarged thyroid	<input type="checkbox"/> concussions
<input type="checkbox"/> itchy eyes	<input type="checkbox"/> grinding teeth	<input type="checkbox"/> Excessive phlegm (color?)	<input type="checkbox"/> nose bleeds	<input type="checkbox"/> other head or neck: _____
<input type="checkbox"/> spots in eyes	<input type="checkbox"/> TMJ	_____	<input type="checkbox"/> ringing in ears	_____
<input type="checkbox"/> poor vision	<input type="checkbox"/> facial pain		<input type="checkbox"/> poor hearing	_____
<input type="checkbox"/> blurred vision	<input type="checkbox"/> gum problems			

Respiratory:

<input type="checkbox"/> difficulty breathing when lying down	<input type="checkbox"/> cough color of phlegm: _____	thick or thin? _____	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> tight chest	wet or dry? _____	<input type="checkbox"/> coughing blood	
		<input type="checkbox"/> asthma/wheezing	
		<input type="checkbox"/> pneumonia	

Cardiovascular

<input type="checkbox"/> high blood pressure	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> tachycardia	<input type="checkbox"/> fainting	<input type="checkbox"/> heart palpitations
	<input type="checkbox"/> chest pain	<input type="checkbox"/> phlebitis	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> irregular heartbeat
		<input type="checkbox"/> blood clots		

Gastrointestinal

<input type="checkbox"/> nausea	color _____	<input type="checkbox"/> laxative use	<input type="checkbox"/> bloody stools
<input type="checkbox"/> diarrhea		<input type="checkbox"/> burning anus	<input type="checkbox"/> hemorrhoid
<input type="checkbox"/> intestinal pain or cramping	<input type="checkbox"/> vomiting	<input type="checkbox"/> gas	<input type="checkbox"/> bloating
bowel movements: frequency _____	<input type="checkbox"/> constipation	<input type="checkbox"/> black stools	<input type="checkbox"/> mucous in stools
	<input type="checkbox"/> itchy anus	<input type="checkbox"/> rectal pain	<input type="checkbox"/> anal fissures
	<input type="checkbox"/> acid regurgitation	<input type="checkbox"/> hiccup	<input type="checkbox"/> bad breath

Musculoskeletal

<input type="checkbox"/> neck/shoulder pain	<input type="checkbox"/> joint pain	<input type="checkbox"/> muscle pain	<input type="checkbox"/> limited use other (describe)
<input type="checkbox"/> upper back pain	<input type="checkbox"/> limited range of motion	<input type="checkbox"/> low back pain	_____
		<input type="checkbox"/> rib pain	

Skin and Hair

rashes
 eczema
 dandruff

change in hair/skin texture
 hives
 psoriasis

itching
 fungal infections
 ulcerations
 acne

hair loss
other hair or skin problems

Neuropsychology

seizures
 poor memory

irritability
 numbness
 depression

easily stressed
 tics
 anxiety

considered/attempted suicide
 seeing a therapist

other (specify):

Genito-urinary

pain on urination
 blood in urine
 frequent urination
 unable to hold urine

bedwetting
 urgent urination

incomplete urination
 wake to urinate

kidney stones
 nocturnal emission

Gynecology

age menses began
 duration of flow
length of cycle (day 1 to day 1) _____
 irregular periods
 painful periods
 breast lumps
 #live births
 #pregnancies
 clots

Patient signature: _____

Date: _____