Patient's History

Today's Date____/_____/______.

Current Symptoms____

____

____

____

Have you had acupuncture before?   Yes / No

How long have you had this condition? ___________________ Is it getting worse?   Yes / No

What is your nature of pain? burning, aching, etc

How is your level of discomfort at rest? (Circle one) 0-1, 2-4, 5-7, 8-10

How is your level of discomfort at moving? (Circle one) 0-1, 2-4, 5-7, 8-10

What seemed to be the initial cause? ____

What seems to make it better? ___________What seems to make it worse?______________

Does it bother your sleep, work, or other? ____

Are you under the care of a physician now? ____

Other therapies? ____

Family medical history

__Allergies
__Asthma
__Alcoholism
__Cancer
__Diabetes
__Heart disease
__High blood pressure
__Seizure
__Stroke

Your medical history

__AIDS/ HIV
__Alcoholism
__Allergies
__Appendicitis
__Arteriosclerosis
__Asthma
__Birth trauma
__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
__Thyroid disorder
__Major trauma
__Tuberculosis
__Thyphoid fever
__Ulcers
__Venereal disease
__Whooping cough

List your surgery ____
List your daily menu:
Breakfast____
Lunch____
Dinner____
List your Supplements ____
Pharmaceutical drug ____
Please describe your current exercise regimen:
Hours per week: _____ Activities: _____________________ No Exercise ______

Your habit

__Coffee/tea
__Soft drink/ juice
__Sugar Craving
__Salty food
__Alcohol
__Tobacco
__Drugs
__Stress
__Occupational hazards

Check all that apply (past and current)

General symptoms

__Poor/ Heavy appetite
__Strongly like cold/hot
__Recent wt loss/ gain
__Poor/ heavy sleep
__Dream-disturb sleep
__Fatigue
__Lack of strength
__Bodily heaviness
__Cold hands or feet
__Poor circulation
__Shortness of breath
__Fever
__Chills
__Night sweats
__Sweat easily
__Muscle cramps
__Vertigo or dizziness
__Bleed or bruise easily
__Taste in mouth

Head, eyes, ears, nose, throat

__Glasses
__Eye strain
__Eye pain
__Red eyes
__Itchy eyes
__Spots in eyes
__Poor vision
__Blurred vision
__Night blindness
__Myopia or presbyopia
__Glaucoma
__Cataracts
__Teeth problems
__Grinding teeth
__TMJ
__Facial pain
__Gum problems
__Sores on lips / tongue
__Dry mouth
__Excessive saliva
__Sinus problems
__Excessive phlegm
__Recurrent sore throat
__Swollen glands
__Lumps in throat
__Enlarged thyroid
__Nosebleed
__Ringing in ears
__Poor hearing
__Earaches
__Headaches
__Migraines
__Concussions
__Other problems

Respiratory

__Difficulty breathing
__when lying down.
__Shortness of breath
__Tight chest
__Asthma /wheezing
__Difficult inhalation?
__Exhalation
__Cough (wet/ dry)
__Coughing up blood
__Pneumonia

Cardiovascular

__High blood pressure
__Blood clot
__Low blood pressure
__Fainting
__Chest pain
__Difficulty breathing
__Tachy cardia
__Heart palpitations
__Phlebitis
__Irregular heart beat

Gastrointestinal

__Nausea
__Vomiting
__Acid regurgitation
__Gas
__Hiccup
__Bloating
__Bad breath
__Diarrhea
__Constipation
__Black stools
__Bloody stools
__Mucous in stools
__Hemorrhoid
__Itchy anus
__Intestine pain/ cramp
__Burning anus
__Rectal pain
__Laxative use
__Bowel frequency
__Bowel quality

Musculoskeletal

__Neck/ Shoulder pain
__Muscle pain
__Upper back pain
__Low back pain
__Joint pain
__Rib pain
__Limited ROM

Skin and hair

__Rashes
__Eczema
__Psoriasis
__Acne
__Dandruff
__Itching
__Hair loss
__Fungal infections
__Other

Neuropsychological

__Seizure
__Numbness
__Tics
__Poor memory
__Depression
__Anxiety
__Irritability
__Easily stressed
__Abuse survivor
__Considered suicide
__Seeing a therapist

Genitourinary

__Pain on urination
__Frequent urination
__Urgent urination
__Blood in urine
__Unable to hold urine
__Incomplete urination
__Venereal disease
__Bedwetting
__Wake to urinate
__Increased libido
__Decreased libido
__Kidney stone
__Impotence
__Premature ejaculation
__Nocturnal emission

Gynecology

Age menses began_____
Date of last PAP_______
___Irregular periods
___PMS
___Menopausal syndrome
Length of cycle_____
Date last period began_____
___Vaginal discharge
___Clots
Duration of flow____
Age at menopause____
___Breast lumps
___Pregnancy