Name _____ Date _____

What are you seeking treatment for? _____

Have you ever had acupuncture before? If so, for what condition? _____

Do you bruise or bleed easily? ❑ Yes ❑ No

Pain l r b = left, right, both

past	current		past	current		past	current		past	current	
❑	❑	head	❑	❑	lower arm l r b	❑	❑	upper back	❑	❑	shin l r b
❑	❑	jaw	❑	❑	wrist l r b	❑	❑	mid-back	❑	❑	ankle l r b
❑	❑	neck	❑	❑	hand l r b	❑	❑	lower back	❑	❑	foot l r b
❑	❑	throat	❑	❑	fingers l r b	❑	❑	hip	❑	❑	heel l r b
❑	❑	shoulder l r b	❑	❑	chest	❑	❑	thigh l r b	❑	❑	toes l r b
❑	❑	upper arm l r b	❑	❑	rib/flank l r b	❑	❑	knee l r b			
❑	❑	elbow l r b	❑	❑	abdomen	❑	❑	calf l r b			

Other current related symptoms_____

past	current		past	current		past	current	
❑	❑	nausea	❑	❑	gas	❑	❑	diarrhea
❑	❑	vomiting	❑	❑	abdominal bloating	❑	❑	constipation
❑	❑	belching	❑	❑	abdominal pain	❑	❑	blood in stools / black stools
❑	❑	heartburn	❑	❑	decreased appetite	❑	❑	pus in stools
❑	❑	bad breath	❑	❑	indigestion	❑	❑	hemorrhoids
❑	❑	bleeding gums	❑	❑	low energy / fatigue	❑	❑	anal fissures
❑	❑	ulcers	❑	❑	crave sweets	❑	❑	rectal pain
❑	❑	excessive appetite	❑	❑	decreased ability to taste or smell	❑	❑	nose bleeds
❑	❑	change in appetite	❑	❑	sweet taste in mouth	❑	❑	recurring sore throat
			❑	❑	often feel pensive / thoughtful	❑	❑	difficulty swallowing
			❑	❑	edema	❑	❑	laryngitis / hoarse voice

Other current related symptoms_____

past	current		past	current		past	current	
❑	❑	frequent colds	❑	❑	asthma	❑	❑	dry skin
❑	❑	sinus infection	❑	❑	bronchitis	❑	❑	itching
❑	❑	cough	❑	❑	pneumonia	❑	❑	acne
❑	❑	cough with blood	❑	❑	chronic obstructive pulmonary disease	❑	❑	rashes
❑	❑	production of phlegm	❑	❑	often feel sad	❑	❑	hives
❑	❑	hay fever or allergies	❑	❑	crave pungent foods	❑	❑	eczema
						❑	❑	psoriasis

Other current related symptoms_____

past	current		past	current		past	current	
❑	❑	frequent urination	❑	❑	frequent urinary tract infections	❑	❑	impotence
❑	❑	urgency to urinate	❑	❑	frequent vaginal infections	❑	❑	premature ejaculation
❑	❑	pain on urination	❑	❑	pelvic inflammatory disease	❑	❑	testicular lumps
❑	❑	urine / bowel incontinence	❑	❑	abnormal PAP smear	❑	❑	prostatitis
❑	❑	weak urine stream	❑	❑	irregular periods			
❑	❑	blood in urine	❑	❑	premenstrual syndrome	❑	❑	genital itching / pain
❑	❑	kidney stones	❑	❑	painful menstrual periods	❑	❑	genital lesions / discharges
❑	❑	low back pain	❑	❑	abnormal bleeding	❑	❑	decreased libido
❑	❑	sore / weak knees	❑	❑	menopause symptoms			
❑	❑	crave salty foods	❑	❑	breast lumps	❑	❑	ear ringing – low pitch
❑	❑	often feel afraid				❑	❑	ear ringing – high pitch
						❑	❑	decreased hearing
						❑	❑	ear infections

Name _____ Date _____

Total Pregnancies _____ Living _____ Ectopic _____ Miscarriages _____ Induced Abortions _____

Other current related symptoms_____

Family History -- Complete for each family member placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer/Tumor, Type:							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug/Alcohol Use							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Other							
Age at Death							

Allergies (ex., food, hay fever, pollen, drugs, medication, etc.) _____

_____

_____

past current
- ❑ ❑ dry eyes
- ❑ ❑ red eyes
- ❑ ❑ eye inflammation
- ❑ ❑ blurred vision
- ❑ ❑ poor night vision
- ❑ ❑ floaters (spots in visual field)
- ❑ ❑ visual changes
- ❑ ❑ glasses / contact lenses
- ❑ ❑ cataracts
- ❑ ❑ crave sour foods

past current
- ❑ ❑ insomnia
- ❑ ❑ excessive / vivid dreams
- ❑ ❑ grinding teeth
- ❑ ❑ depression
- ❑ ❑ anxiety / stress
- ❑ ❑ irritability
- ❑ ❑ treated for emotional / psychological problems
- ❑ ❑ indecisiveness
- ❑ ❑ often feel angry

past current
- ❑ ❑ migraine
- ❑ ❑ dizziness
- ❑ ❑ fainting
- ❑ ❑ seizures
- ❑ ❑ localized weakness
- ❑ ❑ numbness or tingling of limbs
- ❑ ❑ tremors
- ❑ ❑ poor coordination
- ❑ ❑ paralysis
- ❑ ❑ aversion to wind
- ❑ ❑ tendonitis
- ❑ ❑ gallstones

Other current related symptoms_____

past current
- ❑ ❑ high blood pressure
- ❑ ❑ low blood pressure
- ❑ ❑ palpitations
- ❑ ❑ irregular heart beat

past current
- ❑ ❑ chest pain or pressure
- ❑ ❑ jaw, neck, shoulder or arm pain
- ❑ ❑ nausea
- ❑ ❑ swollen hands or feet

past current
- ❑ ❑ blood clotting disorders
- ❑ ❑ phlebitis
- ❑ ❑ poor memory
- ❑ ❑ crave bitter foods
- ❑ ❑ usually feel happy

Other current related symptoms_____

past current
- ❑ ❑ fevers
- ❑ ❑ frequent or strong thirst
- ❑ ❑ tend to feel warmer than others
- ❑ ❑ night sweats
- ❑ ❑ sweat easily
- ❑ ❑ prefer cold food and drink

past current
- ❑ ❑ chills
- ❑ ❑ cold hands / feet
- ❑ ❑ tend to feel colder than others
- ❑ ❑ cold sweats
- ❑ ❑ prefer warm food and drink

past current
- ❑ ❑ headache
- ❑ ❑ neck stiffness
- ❑ ❑ concussion
- ❑ ❑ enlarged lymph glands

Tumors or lumps _____

Name ____ Date _______________________________

♦♦

Past or current infections ____

____

What is your ethnic heritage? ____

How many generations have you been in this country? ____

Please provide a list of the significant places you have lived in your life and the duration of time you lived in each place.

Location	**Date(s) In/Out or Duration of Stay**

Please list your family members (partners, siblings, parents, etc.) ____

____

____

____

Major Hospitalizations – Please list any hospitalizations or surgeries you have undergone.

Year	**Operation or Illness**	**Name of Hospital**	**City and State**

Medicines, Herbs and Supplements – Check any medications you are currently taking

- ❑ aspirin
- ❑ ibuprofen
- ❑ acetaminophen (Tylenol)
- ❑ oral contraceptives
- ❑ other, please list
- ❑ antacids
- ❑ fiber or other laxatives
- ❑ diet pills
- ❑ allergy medication
- ❑ blood thinners
- ❑ blood pressure pills
- ❑ insulin
- ❑ sleeping pills
- ❑ tranquilizers
- ❑ anti-depressants

Name _____ Date _____

Western Drugs

Drug	Dosage	Frequency

Herbs & Supplements

Type	Brand	Dosage	Frequency

Habits – Please check any habits which apply to you now or in the past

	Yes	No	# per day / week	Age started	Age quit
Coffee					
Other Caffeine (tea)					
Tobacco					
Marijuana					
Alcohol					
Other Drugs					

Please describe any restricted diet you follow(ed) now or in the past (ex. no red meat, vegan, vegetarian).

_____

_____

Please describe your typical diet.

	TIME	DESCRIPTION
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		

How many 8 oz. cups of water do you drink daily? _____

Name _____ Date _____

How is your dental health? (Do you have receding gums, gingivitis, etc.? Do you floss and/or use mouth wash, etc.?) When was your last visit to the dentist?

Please describe any regular program of exercise.

Do you have any religious or spiritual practice? If so, please describe.

What are the top priorities in your life?

What are your goals for your health?

Please provide any additional information about yourself or your condition not covered by the above questions.

Are you seeing other practitioners? ❑ Yes ❑ No

If yes, please provide practitioner(s) contact information and any specialties they may have.

_____

_____

_____

Would it be all right to contact this/these practitioner(s) regarding your care? ❑ Yes ❑ No