NAME_____DATE_____

PHONE(home)_____(work)_____ _____cell_____

E-mail (for office use only)_____

ADDRESS_____

CITY/STATE_____ZIP_____

AGE_____HEIGHT_____WEIGHT_____SEX_____MARITAL STATUS_____

BIRTH DATE_____OCCUPATION_____

EMPLOYERS NAME_____

EMPLOYERS ADDRESS_____

PERSONAL PHYSICIAN_____

DATE OF LAST PHYSICAL EXAMINATION_____

EMERGENCY CONTACT_____RELATIONSHIP_____PHONE_____

REFERRED BY_____

Acupuncture has been explained to me as a treatment consisting of inserting needles through the skin at specific points on the surface of the body,(small amount of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Massage, acupressure, acupuncture, reflexology, preventative or corrective exercise and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. It is recommended that you CONSULT YOUR PHYSICIAN for any serious conditions and get at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications can result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax and aggravation to present symptoms. Client further understands and agrees to hold harmless, to indemnify and protect against court action the therapist, management and owners of this clinic, in the unlikely event of accidental injury on these premises**.**

Signed_____**Date**_____

FAMILY MEDICAL HISTORY: parents and grandparents health

__Cancer	__Diabetes	__High or Low Blood Pressure
__Heart Disease	__TB/Emphysema	__Allergies/Sinus problems
__Kidney Disease	__ Epilepsy/Seizures	__Asthma
__Liver Disease	__ Stomach Ulcers	__Mental Disorders
__Eye Disease	__Arthritis	__Alcoholism
__Spinal Problems	__Osteoarthritis	__Drug Addiction

MAJOR COMPLAINT, INJURY OR ILLNESS

Describe when it began and what caused it or how it started:

Have you ever had this condition or similar condition before? Yes No

Have you ever received treatment? Yes No

If yes, when? By whom? What was the diagnosis?

Has the treatment gotten: __Better __Worse __Is about the same

What makes it Better? What makes it worse?

PERSONAL MEDICAL HISTORY

Major Surgeries Illnesses-Disease Accident (please date is possible)

Please List all Medications Vitamins Herbs

CONTAGIOUS DISEASES (Check if you have ever had or currently have one of the following):

__Hepatitis __AIDS __ HIV + __Venereal Disease __Herpes __Other

ALLERGIES drugs foods animals seasonal

LIFESTYLE

HABITS:

__Cigarettes __Soft Drinks __Salt
__Coffee __Alcohol __Recreational Drugs
__Black Tea __Sugar __Stress Scale 1 2 3 4 5 6 7 8 9 10

EXERCISE:

__Never __Little __Moderate __Heavy Type of exercise?

EMOTIONS:

__Happy __Worry __Easily Irritable __Difficulty making decisions
__Angry ___Sad __Cry easily __Hurry to do things
__Fearful __Anxiety __Over think or worry __History of Depression?

DIET (please mark with x all foods eaten and cross off foods you avoid)

__Beef __Eggs __Cheese __Grains __Tofu
__Pork __Bread __Margarine __Fried Food __Yogurt
__Poultry __Milk __Ice Cream __Sweet __Health Bars
__Fish __Butter __Vegetables __Salads __Hot Spicy

Other Cravings

Do you eat three meals per day? Yes No

Do you eat at regular hours? Yes No what times do you eat?

APPETITE:

__Up and Down __Poor __Constant hunger __Loss of taste __Normal

WEIGHT:

__Underweight __Overweight __Recent gain __Recent loss __Normal

ENERGY:

__Up and Down __Low __Excess
__Tired in afternoon __Wake up tired
__Low after eating __Normal

GENERAL SYMPTOMS

BODY TEMPERATURE:

__Warm natured __Flushed Face
__Cold natured __Warm palms Warm soles
__Cold hands and feet __ Feel warm late afternoon or night

PERSPIRATION:

__Very Little __Easily __Night sweats
__Profuse __Palms __Bad smell
__Without exertion __Feet __Normal

DIGESTION AND BOWELS

__Indigestion __Nervous Stomach __Bloating
__Heartburn __Nausea/Vomiting __Full feel or distention
__Belch or burp __Stomach noises __Abdominal pain or cramps
__Gas __Bad breath __Difficulties with fatty or oily food
__Bitter taste in mouth __Gallstones __Weight Problems
__Ulcers __Normal

BOWELS:

How frequent do you have a bowel movement? _____times daily

__Loose stool __Blood in stool __Undigested food in stool
__Diarrhea __Small amount of stool __Stool with very bad smell
__Formed stool __Black stool __Constipation: for how long?
__Hard stool __Mucous in stool __Anus Itch
__Colon problems __Burning Anus __Hemorrhoids
__Intestinal worms/parasites __Pain or cramps __Use of laxatives

URINATION:

__Frequent __Burning __Bladder infections

HISTORY OF:

__Nighttime __Blood __Incontinence __Kidney Stones
__Profuse __Pus __Strong Smell __Kidney infections
__Cloudy __Scanty __Painful
__Not normal color __Urgency __Genital Pain
__Prostrate Problems __Pain or burning during urination __Dribble urine __Normal

THIRST:

__Less than normal __Prefer cold drinks __Prefer hot/warm drinks __Excessive thirst

SLEEP:

__Difficulty falling asleep __Lots of dreams __Tired upon rising
__Awake easily __Nightmares __Sleep too much
__Difficulty going back to sleep __Restless __Normal

How many hours of sleep do you prefer?_____ How many do you actually get?_____

HEADACHES - DIZZINESS:

__Headaches __Vertigo __Bend down/up dizziness
__Dizziness __Motion sickness __Poor balance
__Faint easily __Migraines __Poor memory
__Normal

SKIN:

__Dry __Hives __Clammy
__Oily __Bruise easily __Body odor
__Rashes __Cuts heal slowly __Normal
__Itching __Yellow skin
__Eczema __Boils

HAIR:

__Dry __Dandruff __Early grey
__Oily __Falling out __Normal

EYES:

__Wear glasses/contacts
__Spots or lines in vision
__Poor night vision
__Sensitive to light
__Cataracts
__Glaucoma
__Pain
__Normal
__Red
__Dry
__Itch

EARS:

__Poor hearing
__Ear ache
__Ringing (high pitched)
__Ringing (low pitched)
__Discharges
__Normal

NOSE:

__Current stuffy nose
__Mucous
__Sinusitis
__Hay fever/Allergies
__Bleeding
__Rhinitis
__Sneeze a lot
__Loss of smell
__Normal

Date or season of last cold or flu

MOUTH AND THROAT:

__Dry
__Hoarseness
__Swollen glands
__Gum problems
__Sores in mouth/on tongue
__Feel lump in throat
__TMJ/Grind
__Thyroid problem
__Teeth problems

RESPIRATORY:

__Shortness of breath
__Chest pain
__Asthma
__Bronchitis
__Normal
__Difficulty inhaling
__Difficulty exhaling
__Difficulty breathing when lying down
__Tightness in chest
__Cough with blood
__Dry cough
__Cough with phlegm
__Sigh a lot

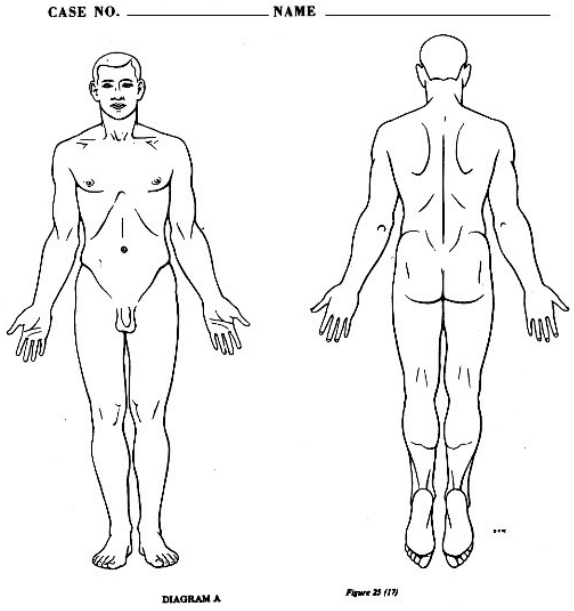
CARDIOVASCULAR - CIRCULATION:

__Diagnosed heart problems
__Low blood pressure
__High blood pressure
__Murmur
__Slow heart beat
__Irregular heart beat
__Normal
__Palpitations
__High cholesterol
__Varicose veins
__Bruise easily
__Numbness of extremities
__History of anemia

PAIN:

__Head
__Neck
__Upper back
__Mid back
__Lower back
__Spine
__Sciatica
__Shoulder
__Elbow
__Hands or wrist
__Hips
__Flank area
__ Knees
__Foot or ankle
__Arthritis
__Damp weather
__Nerve
__Numbness
__Other

Mark areas of pain



FOR FEMALES ONLY:

Are you or might you be pregnant? __Yes __No __Maybe

If yes, what is the approximate date of conception?

Do you have regular Pap Test? __Yes __No How regular?

Do you do regular breast exams? __Yes __No How regular?

GYNECOLOGICAL HISTORY AND OPERATIONS:

__Ovaries __Breast __Uterus __Vagina __Fallopian tubes __Other

What method of birth control do you now use?

What method of birth control have you used in the past?

PREGNANCIES:

Total Number: PREGNANCY OR CHILDBIRTH COMPLICATIONS:

Number of children:

MENSTRUAL CYCLE:

Age started: Age stopped: How many days between periods?

How many days of flow? Describe flow:

Does it begin as bright red or as a darker brownish red?

What is the coloring at the end?

PMS SYMPTOMS

__Irregular __Clotting __Backache

__Water retention __Dark color flow __Sigh a lot

__Light color flow __Scanty flow __Lump in throat feeling

__Abdominal bloating __Heavy flow __Constipation and/or diarrhea

__Painful or tender breast __Painful __Spotting in between cycle

__Breast lumps __Tightness in chest __Hormonal problems

__Emotional changes

VAGINAL DISCHARGE:

__White __Yellow __Thick __Bad odor __Clear

OVULATION SYMPTOMS:

Are you aware of when ovulation occurs? __Yes __No

If so, please describe the symptoms or sensations

Menopausal problems? __Yes __No

Please describe:

FOR OFFICE USE ONLY:

Patient name:_____**Date:**_____

Tongue:

Pulse Rate:_____

Left: HT	**Right: LU**
LV	**SP**
KD Yin	**KD Yang**

Diagnosis:

Treatment Plan:

POINTS USED:

Future Treatment:

Lifestyle and Herbal recommendations: