**DATE:**

**PATIENT INFORMATION:**

Name: Gender:

Age: Date of Birth:

Home Address:

Phone: Email:

Emergency Contact: Relationship to Patient:

Emergency Contact Phone number:

Primary Care Physician (PCP): PCP Phone:

Date of last medical examination:

Do I have permission to contact your PCP regarding your treatment? Yes No

**EXPERIENCE WITH ACUPUNCTURE**

Have you received acupuncture treatment before? YES NO

If yes, for what conditions and what was the outcome?

**What are your main complaints?**

Primary Complaint:

Secondary Complaint:

**PRIMARY COMPLAINT:**

Please answer the following questions focusing on your Primary Complaint ONLY:

1. Briefly explain history of your Primary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?
2. Have you seen a physician (or other primary care provider) for your Primary Complaint? If yes, when and what diagnosis did you receive?
3. Other Care: what other therapies are you doing/ have you done to manage your Primary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/are these other therapies helping?

**SECONDARY COMPLAINT:**

Please answer the following questions focusing on your Secondary Complaint ONLY:

1. Briefly explain history of your Secondary Complaint, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this condition?
2. Have you seen a physician (or other primary care provider) for your Secondary Complaint? If yes, when and what diagnosis did you receive?
3. Other Care: what other therapies are you doing/ have you done to manage your Secondary Complaint, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

On the diagram, please indicate the areas where you feel symptoms associated with your complaints.



**MEDICATIONS, SUPPLEMENTS AND HERBS:**

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you

are CURRENTLY taking:

*Medications, supplements, or herbs: Indication/For treatment of:*

1.
2.
3.
4.
5.

**LIST ANY ALLERGIES (to medications, supplements, herbs):**

**PERSONAL MEDICAL HISTORY:**

**BIRTH:** Describe anything significant/traumatic about your birth:

**VACCINATION HISTORY:** Any unusual reaction? Any unusual vaccination?

**CHILDHOOD ILLNESSES (0-12 years):** Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

**ADOLESCENCE ILLNESSES (13-17 years):** Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

**ADULTHOOD ILLNESSES (18-35 years):** Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

**ADULTHOOD ILLNESSES (36 and up):** Any surgery, accidents and /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE:

AGE:

**FAMILY MEDICAL HISTORY:**

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

MOTHER:

FATHER:

SIBLINGS:

MATERNAL GRANDPARENTS:

PATERNAL GRANDPARENTS:

**SYMPTOM OVERVIEW BY SYSTEM:**

Please check all symptoms that you are CURRENTLY experiencing AND/OR experience FREQUENTLY. Please indicate (by circling) if the symptom is acute, chronic or experienced frequently.

A = Acute (under 3 months)

C = Chronic (over 3 months experience at some point most days)

F = Experience frequently (on and off)

**MUSCULOSKELETAL**

\_\_\_ A C F Joint clicking

\_\_\_ A C F Limitation of movement

\_\_\_ A C F Stiffness

\_\_\_ A C F Spasms or cramps

\_\_\_ A C F Swelling

\_\_\_ A C F Weakness

\_\_\_ A C F Pain: Full body

\_\_\_ A C F Pain: Facial (e.g. jaw)

\_\_\_ A C F Pain: Neck

\_\_\_ A C F Pain: Upper Back

\_\_\_ A C F Pain: Mid Back

\_\_\_ A C F Pain: Low Back

\_\_\_ A C F Pain: Shoulder

\_\_\_ A C F Pain: Elbow

\_\_\_ A C F Pain: Wrist

\_\_\_ A C F Pain: Hand

\_\_\_ A C F Pain: Hip

\_\_\_ A C F Pain: Knee

\_\_\_ A C F Pain: Ankle

\_\_\_ A C F Pain: Foot

\_\_\_ A C F OTHER (Please list)

**EYES, EARS, NOSE and THROAT**

\_\_\_ A C F Loss of vision

\_\_\_ A C F Eye pain

\_\_\_ A C F Tearing or eye dryness

\_\_\_ A C F Eye discharge

\_\_\_ A C F Eye redness

\_\_\_ A C F Ear discharge

\_\_\_ A C F Ear itching

\_\_\_ A C F Ear pain and/or infections

\_\_\_ A C F Loss of hearing

\_\_\_ A C F Ringing or buzzing in ears

\_\_\_ A C F Problems with balance (vertigo)

\_\_\_ A C F Olfaction (sense of smell) impaired

\_\_\_ A C F Nose obstruction (stuffiness)

\_\_\_ A C F Nose bleeds

\_\_\_ A C F Sinus pain, pressure and/or infections

\_\_\_ A C F OTHER (Please list)

**RESPIRATORY**

\_\_\_ A C F Chest pain and/or tightness

\_\_\_ A C F Bluish discoloration of skin

\_\_\_ A C F Cough

\_\_\_ A C F Coughing up blood (hemoptysis)

\_\_\_ A C F Shortness of breath (dypsnea)

\_\_\_ A C F Sore throat

\_\_\_ A C F Sputum production

\_\_\_ A C F Voice changes

\_\_\_ A C F Wheezing

\_\_\_ A C F OTHER (Please list)

**CARDIOVASCULAR**

\_\_\_ A C F Changes in skin temperature

\_\_\_ A C F Chest pain and/or pressure

\_\_\_ A C F Edema

\_\_\_ A C F Fainting (syncope)

\_\_\_ A C F Fatigue

\_\_\_ A C F Palpitations

\_\_\_ A C F Skin ulceration

\_\_\_ A C F Swelling of ankles and/or legs

\_\_\_ A C F OTHER (Please list)

**DIGESTIVE**

\_\_\_ A C F Abdominal distention

\_\_\_ A C F Abdominal mass

\_\_\_ A C F Abdominal pain

\_\_\_ A C F Acid regurgitation and/or Heartburn

\_\_\_ A C F Alternating constipation/diarrhea

\_\_\_ A C F Rectal bleeding

\_\_\_ A C F Constipation

\_\_\_ A C F Diarrhea

\_\_\_ A C F Gas

\_\_\_ A C F Eating disorder

\_\_\_ A C F Indigestion

\_\_\_ A C F Jaundice (yellow tint to skin and/or eyes)

\_\_\_ A C F Nausea

\_\_\_ A C F Vomiting

\_\_\_ A C F OTHER (Please list)

**UROGENITAL**

\_\_\_ A C F Difficulty with urine flow

\_\_\_ A C F Incontinence

\_\_\_ A C F Painful urination (dysurea)

\_\_\_ A C F Rashes

\_\_\_ A C F Red urine

\_\_\_ A C F Urinary tract infection (UTI)

\_\_\_ A C F OTHER (Please list)

**NEUROLOGICAL**

\_\_\_ A C F Changes in consciousness

\_\_\_ A C F Confusion

\_\_\_ A C F Difficulty concentrating

\_\_\_ A C F Dizziness

\_\_\_ A C F Dysphasia (impaired ability to speak)

\_\_\_ A C F Gait disturbance

\_\_\_ A C F Headache

\_\_\_ A C F Numbness and/or tingling

\_\_\_ A C F Loss of consciousness

\_\_\_ A C F Paralysis

\_\_\_ A C F Post shingles pain

\_\_\_ A C F Problems coordinating movements

\_\_\_ A C F Severe forgetfulness

\_\_\_ A C F Tremor

\_\_\_ A C F Visual disturbance

\_\_\_ A C F Weakness

\_\_\_ A C F OTHER (Please list)

**INTEGUMENTARY (SKIN)**

\_\_\_ A C F Changes in hair

\_\_\_ A C F Changes in nails

\_\_\_ A C F Changes in skin color

\_\_\_ A C F Itching (prurites)

\_\_\_ A C F Never sweat

\_\_\_ A C F Rash and/or skin lesion

\_\_\_ A C F Unusual sweating

\_\_\_ A C F Wounds that will NOT heal

\_\_\_ A C F OTHER (Please list)

**PSYCHOLOGICAL**

\_\_\_ A C F Feelings of grief

\_\_\_ A C F Feeling of sadness

\_\_\_ A C F Feeling fearful/anxious/nervous

\_\_\_ A C F Difficulty managing anger

\_\_\_ A C F Feeling manic

\_\_\_ A C F Feeling worried or overly pensive

\_\_\_ A C F Feelings of panic

\_\_\_ A C F Feeling overwhelmed

\_\_\_ A C F Extreme mood swings

\_\_\_ A C F Extreme lack of emotion

\_\_\_ A C F OTHER (Please list)

**SLEEP**

\_\_\_ A C F Difficulty falling asleep

\_\_\_ A C F Dream disturbed sleep

\_\_\_ A C F Wake up and cannot fall back asleep

\_\_\_ A C F OTHER (Please list)

**MISCELLANEOUS**

\_\_\_ A C F Extremely low energy/fatigue

\_\_\_ A C F OTHER (Please list)

**FOR WOMEN ONLY**

\_\_\_ A C F Abnormal vaginal bleeding

\_\_\_ A C F Changes in hair distribution

\_\_\_ A C F Fertility concerns

\_\_\_ A C F Irregular menstruation

\_\_\_ A C F Menopausal symptoms

\_\_\_ A C F No menses

\_\_\_ A C F Pain with menses (dysmenorrhea)

\_\_\_ A C F Pain during or after sexual relations

\_\_\_ A C F Pelvic pain

\_\_\_ A C F Premenstrual symptoms

\_\_\_ A C F Sexual dysfunction

\_\_\_ A C F Unusual discharge

\_\_\_ A C F OTHER (Please list)

**Are you pregnant OR trying to become pregnant?** Y N

**Have you ever been pregnant?** Y N

If yes, how many pregnancies:

# Births:

# Miscarriages:

# Abortions:

**Periods:**

Age of 1st period:

Date of most recent period:

# of days it lasts:

**Have you ever had an abnormal pap result?** Y N

If yes, please describe:

**FOR MEN ONLY**

\_\_\_ A C F Fertility concerns

\_\_\_ A C F Prostate problems

\_\_\_ A C F Sexual dysfunction

\_\_\_ A C F Unusual discharge

\_\_\_ A C F OTHER (Please list)

**MEDICAL DISEASES/CONDITIONS:**

Please check all that apply AND indicate (by circling) if it is chronic or if you had the problem in the past, but is now resolved.

C = Current condition

P = Past condition, but is now resolved.

\_\_\_ C P AIDS/HIV

\_\_\_ C P Alcoholism and/or substance addiction

\_\_\_ C P Allergies

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Anemia

\_\_\_ C P Asthma

\_\_\_ C P Bell.s Palsy

\_\_\_ C P Blood clotting disorder

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Bipolar disorder

\_\_\_ C P Cancer (If yes, pls give history)

\_\_\_ C P Chron.s Disease and/or colitis

\_\_\_ C P Chronic Fatigue Syndrome (CFIDS)

\_\_\_ C P Depression (Major)

\_\_\_ C P Diabetes

\_\_\_ C P Eczema

\_\_\_ C P Endometriosis

\_\_\_ C P Fibroids

\_\_\_ C P Infertility

\_\_\_ C P Lung disease, e.g. COPD

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Fibromyalgia

\_\_\_ C P Gallstones

\_\_\_ C P Heart disease

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Hepatitis A / B / C

\_\_\_ C P Hernia

\_\_\_ C P Herpes

\_\_\_ C P Hypertension

\_\_\_ C P Hypoglycemia

\_\_\_ C P Irritable Bowel Syndrome (IBS)

\_\_\_ C P Joint Replacement

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Kidney Stones and/or Disease

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Lupus

\_\_\_ C P Lyme Disease

\_\_\_ C P Lymph node removal

\_\_\_ C P Mitral valve prolapse

\_\_\_ C P Mood Disorder

\_\_\_ C P Mononucleosus

\_\_\_ C P Multiple Sclerosis

\_\_\_ C P Organ removal or transplant

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Osteoarthritis

\_\_\_ C P Osteoporosis

\_\_\_ C P Pacemaker (heart or stomach)

\_\_\_ C P Parkinson.s Disease

\_\_\_ C P Pelvic Inflammatory Disease

\_\_\_ C P Polio

\_\_\_ C P Psoriasis

\_\_\_ C P PTSD (Post-Traumatic Stress Disorder)

\_\_\_ C P Reflux esophagistis (GERD)

\_\_\_ C P Rheumatic fever

\_\_\_ C P Rheumatoid arthritis

\_\_\_ C P Scarlet Fever

\_\_\_ C P Schizophrenia

\_\_\_ C P Scoliosis

\_\_\_ C P Seizures and /or epilepsy

\_\_\_ C P Shingles

\_\_\_ C P Sleep Disorder

\_\_\_ C P Stroke

\_\_\_ C P Schizophrenia

\_\_\_ C P Thyroid disease

(If yes, pls indicate diagnosis and history)

\_\_\_ C P Ulcer

\_\_\_ C P Trigeminal Neuralgia

\_\_\_ C P Tuberculosis

\_\_\_ C P Vascular disease (e.g. phlebitis)

(If yes, pls indicate diagnosis and history)

\_\_\_ C P OTHER (pls list)

**LIFESTYLE INFORMATION:**

**Stress, Energy Level and Sleep**

What aspects of your life do you enjoy?

What aspects of your life are stressful to you?

Do you think that stress, including any recent major life changes, is contributing to your main complaints and/or negatively impacting any other aspect of your physical or mental health? If yes, briefly describe:

Do you have any problems with your energy level? If yes, please briefly describe:

Do you have any problems with sleep? If yes, please briefly describe:

Do you have any problems with your sexual drive? If yes, please briefly describe:

What do you do for stress reduction?

**Diet and Nutrition**

Please describe what you typically eat throughout the day:

Breakfast (time of day \_\_\_\_):

Lunch (time of day \_\_\_\_\_):

Dinner (time of day \_\_\_\_\_):

Snacks (times of day \_\_\_\_\_):

What beverages do you drink?

How much water do you drink a day?

Do you experience food cravings? If yes, please describe:

Do you wish to make any changes in what you eat? If yes, please describe:

Do you wish to make any changes in what you drink? If yes, please describe:

Do you believe that your diet has any impact on your complaints? YES NO

Please indicate usage per day or per week. Please circle if the usage was in the past

Cigarettes: Per In the past

Alcohol: Per In the past

Recreational Drugs: Per In the past

Tea: Per In the past

Soft Drinks: Per In the past

Sugar: Per In the past

Coffee: Per In the past

Chocolate: Per In the past

Other: Per In the past

**EXERCISE**

Do you get regular exercise? If yes, please describe:

Do you spend time outdoors?

**What are your goals, hopes and expectation for your acupuncture treatments?**