



Have you ever been treated with Acupuncture or Oriental Medicine?

Chief Complaint

Main problem/s you would like help with:

How long ago did this problem begin?

Does anything make it better or worse (e.g. heat, cold, massage, rest, fatigue, etc)?

Have you been given a diagnosis for this problem? If so, what?

What other kinds of treatment have you tried?

Family

Relationship	Alive/Deceased	Present Health/ Cause of Death
Father	_____	_____
Mother	_____	_____

	# Alive	Health	#Deceased	Cause of Death
Brother	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Children/Ages	_____	_____	_____	_____
	_____	_____	_____	_____

Check Illnesses which have occurred in any of your blood relatives:

- Diabetes Cancer Bleeding Tendency Kidney Disease
- Tuberculosis Heart Disease Stroke High Blood Pressure
- Nervous Illness Allergy Other

Past Medical History

Dates of significant illness or surgeries:

Significant illnesses (please circle):

- Cancer Diabetes Hepatitis High Blood Pressure Seizures HIV/AIDS





Significant traumas (e.g. auto accident, falls, etc):

Birth history:

Allergies:

Family medical history:

Head, ears, eyes, nose, throat:

- | | | |
|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Color blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Lip or tongue sores |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Headaches |

Any other problems in this area?

Cardiovascular:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling of the hands | <input type="checkbox"/> Swelling of the feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing |





Any other problems with your heart or vascular system?

Respiratory:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Phlegm | | |

Any other problems with your lungs or respiration?

Gastrointestinal:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Chronic laxative use | |

Any other problems with your stomach or intestines?

Lifestyle

Medicines, vitamins, herbs taken regularly within the last month?

Occupation:

Occupational stresses:





Do you follow a regular exercise program?

Please describe:

Have you ever been on a restricted diet?

Please describe:

Please describe your average daily diet:

Morning:

Afternoon:

Night:

Do you smoke?

How many per day?

How much coffee, tea or soda do you drink per week?

How much alcohol do you drink per week?

Please describe any drug use for non-medical purposes:

General (please check if you have had in the last three months):

Poor appetite

Poor sleeping

Fatigue

Fevers

Chills

Night sweats

Sweat easily

Tremors

Cravings

Localized weakness

Poor balance

Change in appetite

Bleed or bruise easily

Weight loss

Weight gain

Peculiar tastes or smells

Strong thirst

Sudden energy drop





Skin and Hair:

- Rashes
- Itching
- Dandruff
- Changes in hair or skin texture
- Ulcerations
- Eczema
- Loss of hair
- Hives
- Pimples
- Recent moles

Any other skin problems?

Uro-Genital

- Painful urination
- Urgency to urinate
- Decrease in flow
- Frequent urination
- Unable to hold urine
- Impotency
- Blood in urine
- Kidney stones
- Sores on genitals

Do you wake up to urinate?

How often?

Any particular color to urine?

Any other problems with your urinary system or genitals?

Pregnancy

- Number of pregnancies
- Miscarriages/abortions
- Duration of menses
- Heavy or light period
- Irregular periods
- Vaginal sores
- Number of births
- Age at first menses
- Date of last menses
- Painful periods
- Last Pap smear
- Breast lumps
- Premature births
- Number of days between menses
- Yeast infections
- Clots with flow
- Vaginal discharge
- PMS

Do you use birth control?

If so, what type and for how long?





Any other problems in this area?

Musculoskeletal:

- | | | |
|---|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hand/wrist pains | <input type="checkbox"/> Shoulder pains | <input type="checkbox"/> Hip pain |

Any other joint or bone pain?

Neuropsychological:

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Easily susceptible to stress | |

Any other neurological, psychological or mood problems?

Comments:

Please mention any other problems you would like help with or anything else you feel needs to be mentioned:

Signature _____ Date _____

