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:

____Dizziness	____Concussions	____Migraine
____Glasses	____Eye strain	____Eye pain
____Poor vision	____Night blindness	____Color blindness
____Cataracts	____Blurry vision	____Earaches
____Ringing in the ears	____Poor hearing	____Grinding teeth
____Spots in front of eyes	____Facial pain	____Lip or tongue sores
____Teeth problems	____Jaw clicks	____Headaches

Any other problems in this area?

____
____
____

Cardiovascular:

____High blood pressure	____Low blood pressure	____Chest pain
____Irregular heartbeat	____Dizziness	____Fainting
____Cold hands or feet	____Swelling of the hands	____Swelling of the feet
____Blood clots	____Phlebitis	____Difficulty breathing

Any other problems with your heart or vascular system?

____
____
____

Respiratory:

____Cough ____Coughing up blood ____Asthma

____Bronchitis ____Pneumonia ____Pain with deep breath

____Phlegm

Any other problems with your lungs or respiration?

____
____
____

Gastrointestinal:

____Nausea ____Vomiting ____Diarrhea

____Constipation ____Gas ____Belching

____Black stools ____Blood in stools ____Indigestion

____Bad breath ____Rectal pain ____Hemorrhoids

____Abdominal pain or cramps ____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:
____
____
____

<u>General (please check if you have had in the last three months):</u>

___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
___Ulcerations
___Hives
___Itching
___Eczema
___Pimples
___Dandruff
___Loss of hair
___Recent moles
___Changes in hair or skin texture

Any other skin problems?

____
____
____

Uro-Genital

___Painful urination
___Frequent urination
___Blood in urine
___Urgency to urinate
___Unable to hold urine
___Kidney stones
___Decrease in flow
___Impotency
___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
___Number of births
___Premature births
___Miscarriages/abortions
___Age at first menses
___Number of days between menses
___Duration of menses
___Date of last menses
___Yeast infections
___Heavy or light period
___Painful periods
___Clots with flow
___Irregular periods
___Last Pap smear
___Vaginal discharge
___Vaginal sores
___Breast lumps
___PMS

Do you use birth control?

____

If so, what type and for how long?

____

Any other problems in this area?

____
____
____

Musculoskeletal:

___Neck pain
___Back pain
___Hand/wrist pains
___Muscle pains
___Muscle weakness
___Shoulder pains
___Knee pain
___Foot/ankle pain
___Hip pain

Any other joint or bone pain?

____
____
____

Neuropsychological:

___Seizures
___Areas of numbness
___Concussion
___Bad temper
___Dizziness
___Lack of coordination
___Depression
___Easily susceptible to stress
___Loss of balance
___Poor memory
___Anxiety

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________________