The information on this form will help your acupuncturist to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem unrelated to your condition, they may play a contributing or underlying role in diagnosis and treatment of your problem. **All information provided is strictly confidential.**

**GENERAL INFORMATION Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of guardian (if under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number of guardian (if under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**In case of emergency, who should we notify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name of Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What health concerns would you like to address?**

|  |  |
| --- | --- |
| **Health Concern/Symptom** | **For how long?** |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |
| **5.** |  |

**MEDICAL HISTORY**

**Please describe your childhood health:**

**Have you been hospitalized or had any major surgeries? Please include the date(s)**

**Known allergies/sensitivities (food, environmental, drugs, etc.)?**

**Are you currently on an aspirin regimen or taking blood thinners?**

**Are you currently pregnant or trying to conceive?**

**Do you have a blood-borne pathogen (HIV/AIDs, Hepatitis B, etc.)?**

**Please list any medications (prescription and non-prescription), vitamins, and supplements that you take regularly:**

**FAMILY HISTORY**

**Is there a family history of:**

|  |  |
| --- | --- |
| **Condition** | **Relationship** |
| Asthma |  |
| Cancer |  |
| Diabetes |  |
| Heart disease |  |
| High blood pressure |  |
| Lung disease |  |
| Other: |  |

**HEALTH PROFILE**

Please check any of the following symptoms that currently pertain to you

**MUSCULO-SKELETAL**

🞎 Pain or muscle soreness? If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Joint pain? If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Muscle weakness? If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Tremors

🞎 Difficulty walking

🞎 Spinal curvature

🞎 Poor coordination

🞎 Other

**OVERALL BODY TEMPERATURE (Yin and Yang Balance)**

🞎 Cold body temp

🞎 Hot body temp

🞎 Afternoon flushing/fever

🞎 Cold hands

🞎 Cold feet

🞎 Sweaty palms

🞎 Sweaty feet

🞎 Profuse sweating

🞎 Sweating easily

🞎 Lack of sweating

🞎 Hot flashes

🞎 Strong thirst

**OVERALL ENERGY (TCM Lung and Kidney Systems)**

🞎 Easily fatigued

🞎 Low energy/lethargy

🞎 Easily prone to illness

🞎 Sweating without exertion

🞎 Wheezing

🞎 Shortness of breath

🞎 Chronic allergies

**TCM BLOOD FUNCTION (TCM Liver, Heart, and Spleen Systems)**

🞎 Dizziness

🞎 Tingling in extremities

🞎 Itchy or dry skin

🞎 Blurry vision

🞎 Poor night vision

🞎 Poor memory

🞎 Scanty menses

🞎 Weak or brittle nails

🞎 Floaters in eyes

🞎 Fainting

🞎 Difficulty concentrating

**TCM HEART FUNCTION**

🞎 Insomnia

🞎 Mental restlessness

🞎 Vivid or disturbing dreams

🞎 Anxiety

🞎 Depression

🞎 Manic moods

🞎 Hallucinations

🞎 Speech impediment

🞎 Forgetfulness

🞎 Heart disease

🞎 High blood pressure

🞎 Low blood pressure

🞎 Arrhythmia

🞎 Heart murmur

🞎 Mitral valve prolapse

🞎 Hemophilia

🞎 Chest pain

🞎 Awareness of heart beat

🞎 Vein condition

🞎 Tongue ulcers

**TCM LUNG FUNCTION**

🞎 Cough

🞎 Chronic allergies

🞎 Dry or flaky skin

🞎 Nosebleeds

🞎 Nasal dryness

🞎 Sneezing

🞎 Difficulty breathing

🞎 Sinus congestion

🞎 Sore throat

🞎 Wheezing

🞎 Grief

🞎 Skin rashes

🞎 Skin ulceration

🞎 Hives

🞎 Eczema

🞎 Emphysema

🞎 Lung disease

🞎 Asthma

🞎 Phlegm

🞎 Cigarette smoker

**TCM SPLEEN FUNCTION**

🞎 Low or weak appetite

🞎 Abdominal gas or bloating

🞎 Gurgling in intestines

🞎 Hemorrhoids

🞎 Feeling tired after eating

🞎 Strong food cravings

🞎 Bruise easily

🞎 History of hernia

🞎 Hypoglycemia

🞎 Abrupt weight loss or gain

🞎 Digestive pain

🞎 History of organ prolapse

**TCM STOMACH FUNCTION**

🞎 Stomachache

🞎 Bleeding gums

🞎 Mouth sores

🞎 Bad breath

🞎 Belching

🞎 Ravenous appetite

🞎 Stomach ulcer

🞎 Vomiting

🞎 Nausea

🞎 Heartburn

🞎 Acid reflux

🞎 Frequent hiccups

**BOWEL FUNCTION and ELIMINATION**

🞎 Loose stools

🞎 Diarrhea (3+ BM per day)

🞎 Small, hard, or dry stools

🞎 Constipation (3 or less BM per week)

🞎 Blood in stools

🞎 Mucous in stools

🞎 IBS or Colitis

🞎 Chron’s disease

🞎 Black or tarry stools

🞎 Incomplete stools

🞎 Difficulty moving bowels

🞎 Abdominal pain

🞎 Rectal pain

🞎 Eating disorder

**DAMPNESS**

🞎 Brain fog

🞎 Swollen hands or feet

🞎 Mental sluggishness

🞎 Edema in legs

🞎 Edema in abdomen

🞎 Joint stiffness/achiness

🞎 Chest congestion

🞎 Poor mental focus

🞎 Feeling of heaviness of the head, limbs, or whole body

🞎 Symptoms are worse in rainy weather

🞎 Lump in throat

**TCM LIVER and GALL BLADDER FUNCTION**

🞎 Chest pain

🞎 Irritability

🞎 Depression

🞎 Skin rashes

🞎 Chest tightness

🞎 Easy to anger

🞎 Acne

🞎 All over body tension

🞎 Migraines

🞎 Headaches

🞎 Heaviness or pain in ribcage area

🞎 Seizures

🞎 Muscle spasms

🞎 Convulsions

🞎 Chronic neck tension

🞎 Easily frustrated

🞎 Muscle cramps

🞎 Numbness or tingling

🞎 Shoulder tension

🞎 Gall stones

🞎 Ringing in ears

🞎 Liver disease

🞎 Alternating diarrhea and constipation

🞎 Easily overwhelmed by stressful circumstances

🞎 Severe shyness

**EYES (Liver Function)**

🞎 Itchy eyes

🞎 Dry eyes or grittiness

🞎 Bloodshot

🞎 Far sighted

🞎 Seeing spots

🞎 Watery eyes

🞎 Astigmatism

🞎 Near sighted

🞎 Glaucoma

🞎 Blurry vision

🞎 Poor night vision

**TCM KIDNEY FUNCTION**

🞎 Frequent cavities

🞎 Broken or loose teeth

🞎 Weak knees

🞎 Knee soreness

🞎 Weak bones

🞎 Cold knees

🞎 Hearing loss

🞎 Ringing in ears

🞎 Hair loss

🞎 Early graying of hair

🞎 Low back pain

🞎 Kidney disease

🞎 Urinary incontinence

🞎 Prostate problems

🞎 Cold low back, hips or buttocks

🞎 Quick to fear/fright

**TCM BLADDER FUNCTION**

Urine color: 🞎 clear 🞎 light yellow 🞎 dark yellow 🞎 reddish/amber 🞎 cloudy

Urine frequency: 🞎 rare 🞎 normal 🞎 very frequent

Urine amount: 🞎 small 🞎 normal 🞎 large

🞎 Frequent UTIs

🞎 Pain or burning

🞎 Strong odor

🞎 Dribbling

🞎 Weak stream

🞎 Difficulty initiating stream

🞎 Hesitancy

🞎 Getting up at night to urinate

**LIBIDO and SEXUAL FUNCTION**

🞎 Normal sex drive

🞎 High sex drive

🞎 Diminished sex drive

🞎 Infertility

🞎 Fatigue after sexual activity

**MALE-BODIED**

🞎 Prostate problems

🞎 Early ejaculation

🞎 Spermatorrhea

🞎 Nocturnal emissions

🞎 Thick or dense semen

🞎 Discolored or yellow semen

🞎 Difficulty getting or maintaining an erection

🞎 Pain in penis or testicles

🞎 Other

**FEMALE-BODIED**

🞎 Vaginal infections

🞎 Pelvic infection

🞎 Vaginal dryness

🞎 Difficulty achieving orgasm

🞎 Fibroids

🞎 Ovarian cysts

🞎 PCOS
🞎 Endometriosis

🞎 Hot flashes

🞎 Breast lumps

🞎 Pain/cramping with cycle

🞎 Back pain with cycle

🞎 Headaches with cycle

🞎 Breast tenderness

🞎 Intense emotions w/ cycle

🞎 Irregular periods

Number of pregnancies \_\_\_\_

Number of children \_\_\_\_

Birth control? What type? How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First day of last period \_\_\_\_\_\_\_ Age of 1st menses \_\_\_\_\_\_\_\_\_\_\_\_\_

Number of days in full cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of flow \_\_\_\_\_\_\_\_\_\_\_\_\_

Blood color: 🞎 light red 🞎 bright red 🞎 red 🞎 dark red 🞎 brown 🞎 very dark/black

Clots? If so, what size: 🞎 small 🞎 medium 🞎 large

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature or (Patient Representative)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name or Patient Representative (Please Print)**