COMPREHENSIVE ACUPUNCTURE EXAMINATION

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

NAME _____ Date _____ SS# _____ Home Phone _____

Birth Date: _____ Street _____ City _____ Work Phone _____

Major Complaint/s _____

_____

_____

Other Complaints: _____

_____

Date on onset (when your first noticed your problem)? _____

Pain is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

How long have you had this condition? _____

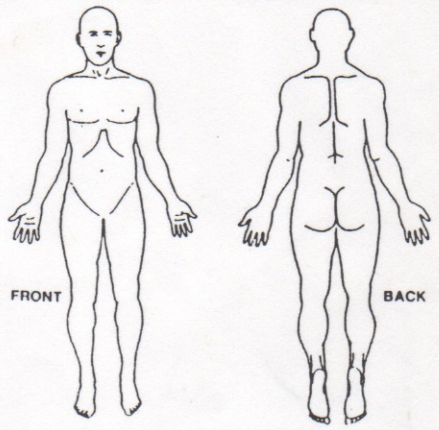
Have you had this in the past? ☐ Yes ☐ No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and Goes

PLEASE MARK YOUR AREAS OF PAIN



Medications/Drugs/Herbs you are currently taking: _____

_____

List Surgeries/Operations you have had and dates: _____

_____

Date of your last physical examination _____ By whom? _____

MEDICAL HISTORY: (Do you have or have you ever had): ☐ Arthritis ☐ Asthma ☐ Anemia ☐ Heart trouble ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Stroke ☐ Kidney or bladder trouble ☐ Gallstones ☐ Ulcers ☐ High blood pressure ☐ Chronic fatigue ☐ Hepatitis ☐ Jaundice ☐ Sudden weight loss ☐ Sudden weight gain

Other: _____

FAMILY HISTORY: (Has any member of your family had any of the above)? ☐ Yes ☐ No If yes, which member and what did they have? _____

ENERGY LEVEL: ☐ High (Time of day) _____ ☐ Low (Time of day) _____

STRESS: ☐ None ☐ Moderate ☐ Severe What causes it? _____

SWEATING: ☐ Night sweats ☐ Rarely sweat ☐ Excess sweating _____

CIRCULATION: Feelings of ☐ Hot ☐ Cold What area? _____

☐ Bleed easily ☐ Cold limbs Other: _____

SKIN: ☐ Dry ☐ Itchy ☐ Moist/clammy ☐ Burning ☐ Changing moles or lumps (cysts/tumors) ☐ Boils ☐ Frequent skin rashes ☐ Acne ☐ Hair loss/thinning ☐ Dry scalp ☐ Skin puffy/wrinkled

☐ Bruises easily (black and blue spots) ☐ Hives Other: _____

SCARS: (List ALL scars from accidents or surgeries) _____

_____

SLEEP PROBLEMS: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Excess dreaming

Other: _____ How many hours do you sleep a night? _____

HEAD: ☐ Headaches (what area?) _____ ☐ Dizziness ☐ Memory loss ☐ Loss of balance

Other: _____

EYES: ☐ Eye pain ☐ Dry eyes ☐ Blurred vision ☐ Darkness under eyes Other: _____

_____

EARS: ☐ Poor hearing ☐ Earaches ☐ Ear discharge/infections ☐ Ringing/buzzing in ears

Other: _____

NOSE: ☐ Frequent nose bleeds ☐ Sinus trouble ☐ Frequent colds Other: _____

_____

THROAT: ☐ Sore throat ☐ Hoarseness ☐ Difficulty swallowing ☐ Jaw problems ☐ Teeth/gum problems ☐ Swollen tongue
Other: _____

CHEST: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Mucus rattles when breathing ☐ Trouble breathing at night
☐ Pain/pressure in chest ☐ Palpitations ☐ Persistant cough ☐ Coughing blood ☐ Coughing phlegm
Sputum color _____ Consistency _____
Other: _____

BLOOD PRESSURE: ☐ High ☐ Low ☐ Do not know

BOWELS: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucus in stools ☐ Hemorrhoids
☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems ☐ Number bowel movements a day _____
Other: _____

URINE: Color _____ Amount _____ Frequent urination ☐ Daytime ☐ At night
☐ Strong smelling urine ☐ Hard to urinate ☐ Pain or burning on urinating ☐ Blood in urine
☐ Frequent infections ☐ Water retention Other: _____

MUSCULOSKELETAL: Pain in: ☐ Neck ☐ Shoulder ☐ Between shoulders ☐ Arms/hands ☐ Hip ☐ Knee
☐ Fingers ☐ Big toe ☐ Upper back ☐ Mid back ☐ Lower back ☐ Bones sore/painful ☐ Loss of grip
☐ Swollen knees/elbows ☐ Leg cramps at night ☐ Weakness in legs ☐ Weak ankles ☐ Stiff all over
☐ Tingling in feet ☐ Muscle spasm/cramps ☐ Loss of feeling in hands/feet ☐ Painful joints ☐ Bursitis
Other: _____

NEUROLOGICAL: ☐ Nervousness ☐ Depressed ☐ Easily angered ☐ Easily irritated ☐ Frequent crying
☐ Worry/Anxiety ☐ Mood swings ☐ Memory confusion ☐ Poor concentration ☐ Suicidal ☐ Tremors
☐ Numbness/tingling in limbs ☐ Poor coordination ☐ Muscle weakness ☐ Feel weak and shaky ☐ Seizures
☐ Neuralgia (nerve pain) ☐ Shingles Other: _____
_____

FEMALES: ☐ Pregnant? ☐ yes ☐ No Last monthly period _____ Last PAP test _____
Form of birth control: ☐ None ☐ Pill Other _____
Age started menstrual cycle _____ Age stopped _____ ☐ Menstrual pain ☐ Low backache
☐ Irregular ☐ Clotting ☐ Heavy bleeding ☐ Light scanty bleeding ☐ Color _____
☐ Water retention ☐ Mood changes ☐ Miss periods ☐ Low or no sex drive ☐ Painful breasts ☐ Hot flashes
☐ Food cravings Other: _____
Discharges: ☐ Yellow ☐ Thick ☐ White ☐ Odor ☐ Itching ☐ Liquid Other: _____
No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____
No. Cesareans _____ Operations: ☐ Cervix ☐ Uterus ☐ Ovaries Other: _____

MALES: ☐ Low sexual drive ☐ Lack of sexual drive ☐ Impotence ☐ Ejaculation causes pain ☐ Discharges
☐ Pain or burning while urinating ☐ Premature ejaculation ☐ Prostrate trouble Other: _____
_____

APPETITE: ☐ Excessive appetite ☐ Poor appetite ☐ Appetite keeps changing ☐ Feel tired or weak if a meal is missed
☐ Excessive thirst ☐ Never thirsty Other: _____
Specific food cravings? ☐ Yes ☐ No If yes, what? _____
Other: _____

DIGESTION: ☐ Stomach gas ☐ Lower bowel gas ☐ Heartburn ☐ Burning/belching ☐ Stomach pain
☐ Stomach cramps ☐ Nausea ☐ Vomiting ☐ Bad breath ☐ Sores in mouth ☐ Weight gain ☐ Weight loss
☐ Bitter/sour taste in mouth ☐ Abdominal bloating How long after eating? _____
Food allergies? ☐ yes ☐ No If yes, to what? _____
_____

NUTRITION: List some of your favorite foods _____
_____

Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast
How many meals a day do you eat?_____ When is your biggest meal? _____
Do you eat when you are worried or rushed? ☐ Yes ☐ No How often? _____
Do you plan your meals according to the "Four basic food groups"? ☐ Yes ☐ No
How many glasses of water do you drink a day? _____ ☐ Filtered ☐ Bottled