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: _____ Birth Date: _____ Height: _____ Weight: _____ Date:_____

Major Complaint/s _____

_____

Other Complaints: _____

Date of onset (when you 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? _____

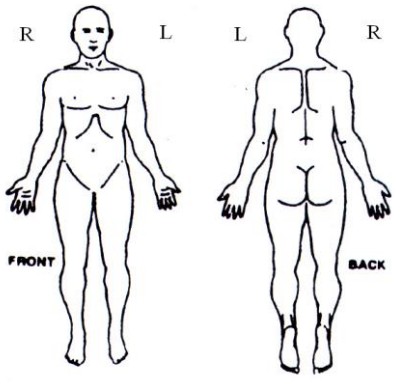
What makes it worse? _____

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

Medications/Drugs/Herbs you are currently taking: _____

_____

PLEASE MARK YOUR AREAS OF PAIN



List Surgeries/Operations you have had and dates: _____

_____

Family Physician: _____Phone:_____ Date of last Exam:_____

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 ☐ HIV+/AIDS Other: _____

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

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

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

BLOOD PRESSURE: ☐ High ☐ Low ☐ Do not know

BOWELS: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Hemorrhoids ☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems. Number of 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 spasms ☐ 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: _____

BIOLOGICAL 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
Discharges: ☐ Yellow ☐ Thick ☐ White ☐ Odor ☐ Itching ☐ Liquid ☐ Other: _____

No. Pregnancies_____ No. Deliveries_____ No. Miscarriages_____ No. Abortions_____ No. Cesareans_____

Operations: ☐ Cervix ☐ Uterus ☐ Ovaries Other: _____

BIOLOGICAL MALES: ☐Low sexual drive ☐ Lack of sexual drive ☐ Impotence ☐ Ejaculation causes pain ☐ Discharges ☐ Pain or burning while urinating ☐ Premature ejaculation ☐ Prostate 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, to 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, what? _____

_____

NUTRITION: List some of your favorite foods_____

Do you: ☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast. How many meals 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

Do you use: Alcohol? ☐ Yes ☐ No Amount per week? _____ Type_____

Tobacco? ☐ Yes ☐ No Packs per day? _____ How many years? _____

DO YOU:

Eat raw fruits or vegetables at least twice a day? ☐ Yes ☐ No

Eat meat or dairy products 2 or more times a day? ☐ Yes ☐ No

Eat green or yellow vegetables at least twice a day? ☐ Yes ☐ No

Eat the same foods almost every day? ☐ Yes ☐ No

Eat frequently between meals? ☐ Yes ☐ No

Eat when you are not hungry? ☐ Yes ☐ No

Chew your food thoroughly before swallowing it? ☐ Yes ☐ No

Eat until you feel full? ☐ Yes ☐No

Always add salt to yours food? ☐ Yes ☐ no

Occasionally go on a "crash" diet? ☐ Yes ☐ No

Drink juice, milk or other drinks instead of water when thirsty? ☐ Yes ☐No

***Patient's Signature:_____Date:_____**

* (Parent or personal representative)