

Name:		Sex:	Age:
Address:		City:	State: Zip Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Date of Birth:		City of Birth:	State of Birth:
Height:	Weight:	Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other : _____	
Employer:		Occupation:	
Physician:		Physician's Phone #:	
How did you hear of our clinic?:		Have you been treated by Acupuncture or Oriental Medicine Before? <input type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___	

**MAIN COMPLAINTS**

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

↓

**1** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 | \_\_\_\_\_ | 10

**2** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 | \_\_\_\_\_ | 10

**3** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 | \_\_\_\_\_ | 10

**HEALTH HISTORY**

Circle the ♀ if you have / had the condition and note the year it started.  
Circle the 👤 if there is a family history of the condition.

	YOU	Year	FAMILY		YOU	Year	FAMILY
Cancer type(s)?	♀ _____		👤 _____	Osteoporosis	♀ _____		👤 _____
Diabetes	♀ _____		👤 _____	Herpes	♀ _____		👤 _____
Hepatitis	♀ _____		👤 _____	AIDS / HIV	♀ _____		👤 _____
High Blood Pressure	♀ _____		👤 _____	Other STD	♀ _____		👤 _____
Heart Disease	♀ _____		👤 _____	Rheumatic Fever	♀ _____		👤 _____
Stroke	♀ _____		👤 _____	Alcoholism	♀ _____		👤 _____
Seizure Disorder	♀ _____		👤 _____	Allergies	♀ _____		👤 _____
Thyroid Disease	♀ _____		👤 _____	Mental Illness	♀ _____		👤 _____
Asthma	♀ _____		👤 _____	Kidney Disease	♀ _____		👤 _____
Pacemaker	♀ _____		👤 _____	Anemia	♀ _____		👤 _____
				Other _____	♀ _____		👤 _____

**HABITS**

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

**EXERCISE**

Do you exercise regularly?  Yes  No  
If so, what and how often:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DIET** Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)  
Describe w/ dates:

**MEDICATIONS**

Please note what medications, herbs or supplements that you take regularly

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INJURIES & SURGURIES**

Please note what happened to what body area and when it occurred (incl. dental)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



*Please mark an X on the scales and check any boxes of symptoms you have had in the past month*

### TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD

HOT

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Thirst for cold / hot drinks | <input type="checkbox"/> Night sweats   | <input type="checkbox"/> Hot hands, feet, chest |
| <input type="checkbox"/> Chills              | <input type="checkbox"/> Thirst, no desire to drink   | <input type="checkbox"/> Unusual sweats | <input type="checkbox"/> Hot flashes            |
| <input type="checkbox"/> Cold "in the bones" | <input type="checkbox"/> Absence of thirst            | When _____ am / pm                      | <input type="checkbox"/> Hot in afternoon       |
| <input type="checkbox"/> Areas of numbness   | <input type="checkbox"/> Excessive thirst             | Where on body _____                     | <input type="checkbox"/> Hot at night           |

### MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY

OILY

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Dry skin          | <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Edema / Swelling _____ | <input type="checkbox"/> Oily skin          |
| <input type="checkbox"/> Dry hair          | <input type="checkbox"/> Dry lips              | <input type="checkbox"/> Rashes _____           | <input type="checkbox"/> Oily hair          |
| <input type="checkbox"/> Dry eyes          | <input type="checkbox"/> Dry throat            | <input type="checkbox"/> Itching _____          | <input type="checkbox"/> Pimples            |
| <input type="checkbox"/> Dry brittle nails | <input type="checkbox"/> Dry nose / Nosebleeds | <input type="checkbox"/> Dandruff               | <input type="checkbox"/> Weight gain / loss |
- Where on your body?:

### DIGESTION

DIARRHEA

CONSTIPATION

- |  |  |  |   |
|--|--|--|---|
| BM: How often? _____ x / every _____ days                                | <input type="checkbox"/> Gas           | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Dry Stools           |
| Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Bloating      | <input type="checkbox"/> Bad breath        | <input type="checkbox"/> Difficult to pass    |
| <input type="checkbox"/> Alternating diarrhea & constipation (IBS)       | <input type="checkbox"/> Belching      | <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Tired after BM       |
| <input type="checkbox"/> Indigestion                                     | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive hunger  | <input type="checkbox"/> Foul smelling stools |

### ENERGY

LOW

HIGH

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Sudden energy drop       | <input type="checkbox"/> Dependence on caffeine / stimulants | <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Hard to concentrate      |
| Time of day: _____ am / pm                        | <input type="checkbox"/> Wired / ungrounded feeling          | <input type="checkbox"/> Heart Palpitations        | <input type="checkbox"/> Poor memory              |
| <input type="checkbox"/> Energy drop after eating | <input type="checkbox"/> Body / Limbs feel heavy             | <input type="checkbox"/> Blood pressure High / Low | <input type="checkbox"/> Dizziness / lightheaded  |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Body / Limbs feel weak              | <input type="checkbox"/> Bleed / Bruise easy       | <input type="checkbox"/> Headaches _____ x / week |

### SLEEP

- # hours per night \_\_\_\_\_
- Difficulty falling asleep
  - Wake \_\_\_\_\_ x / night @ \_\_\_\_\_ am / pm
  - Wake to urinate How often? \_\_\_\_\_
  - Disturbing dreams
  - Restless sleep
  - Not rested upon waking

### EMOTIONS

What emotion(s) dominate your experience?

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Anger              | <input type="checkbox"/> Grief       |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Joy         |
| <input type="checkbox"/> Worry              | <input type="checkbox"/> Fear        |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Timid / shy |
| <input type="checkbox"/> Sadness            | <input type="checkbox"/> Indecision  |

### EYES, EARS NOSE THROAT

- |   |  |
|---|--|
| <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Night blindness        | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes               | <input type="checkbox"/> Excess earwax   |
| <input type="checkbox"/> Itchy eyes             | <input type="checkbox"/> Sore throat     |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Sinus congestion       | <input type="checkbox"/> Mouth sores     |
| <input type="checkbox"/> Phlegm (color _____)   | <input type="checkbox"/> Cough           |

### MENSES

- Age at first menses: \_\_\_\_\_
- Length of full cycle: \_\_\_\_\_ days
- Length of menses: \_\_\_\_\_ days
- Last menses start date: \_\_\_\_\_ / \_\_\_\_\_
- # of pregnancies: \_\_\_\_\_
- # of births: \_\_\_\_\_ premature \_\_\_\_\_
- # of abortions / miscarriages: \_\_\_\_\_

### MENOPAUSE

Age at last menses : \_\_\_\_\_  Hot flashes \_\_\_\_\_ x / day  Vaginal dryness

Year changes began: \_\_\_\_\_  Night sweats \_\_\_\_\_ x / week  Loss of sex drive

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heavy periods                                      | <input type="checkbox"/> Cramps            | <input type="checkbox"/> Mood changes                  |
| <input type="checkbox"/> Light periods                                      | <input type="checkbox"/> Before bleeding   | <input type="checkbox"/> Fatigue w/ menses             |
| <input type="checkbox"/> Painful periods                                    | <input type="checkbox"/> First day         | <input type="checkbox"/> Digestive changes w/ menses   |
| <input type="checkbox"/> Irregular periods                                  | <input type="checkbox"/> During period     | <input type="checkbox"/> Midcycle spotting             |
| <input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS) | <input type="checkbox"/> Clots             | <input type="checkbox"/> Yeast infections              |
|   | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Birth control pill (hormonal) |

Name:  
Today's Date:

Please indicate areas of pain or distress

