

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**I. Goals:** What would you most like to achieve through your work at the ABC Acupuncture Center?

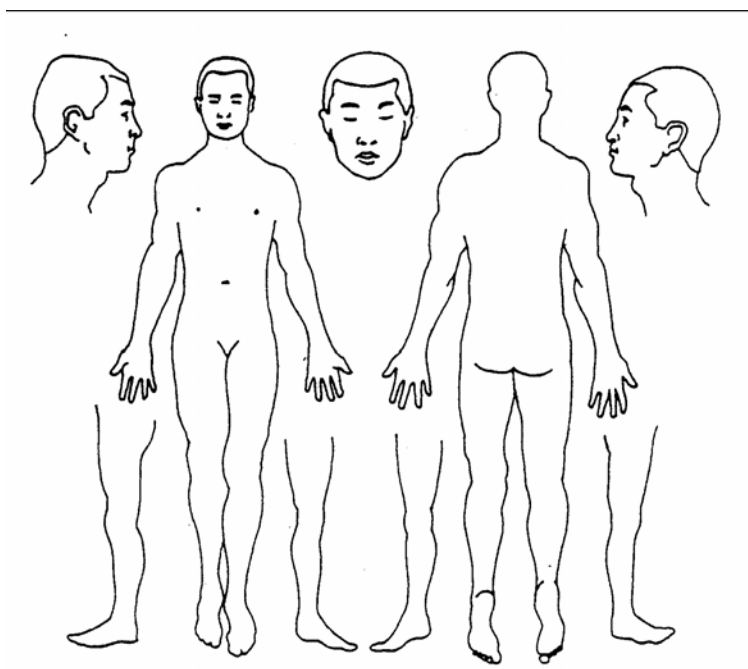
1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**II. Major Symptoms:** Please list in order of importance what symptoms are of concern to you.

*(most concerning to least, along with the duration of the symptom)*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

- X X X Sharp/stabbing
- P P P Pins & Needles
- D D D Dull/Aching
- N N N Numbness

**For Women:**

1. Are you pregnant now? [ ] Yes [ ] No [ ] Unsure
2. Indicate number of occurrences:  
Live Births \_\_\_\_\_ Pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_
3. Age: First period \_\_\_\_\_ Menopause (if applicable) \_\_\_\_\_
4. Date: Last Pap Smear \_\_\_\_\_ / \_\_\_\_\_ Last Mammogram \_\_\_\_\_ / \_\_\_\_\_
5. Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? \_\_\_\_\_

6. Is your menses cycle regular?  Yes  No  
 a) Average number of days of flow \_\_\_\_\_  
 b) The flow is:  Normal  Heavy  Light  
 c) The color is:  Normal  Dark  Purple  Light Brown  Brown

7. Do you have the following menstruation related signs/symptoms?

- Difficulty with Orgasm       Cramps       PMS       Heavy Vaginal discharge between periods  
 Pain with Intercourse       Nausea       Bleeding between Periods  
 Blood Clots       Breast Distention       Vaginal Discharge

**For Men:**

1. Do you have any bothersome urinary symptoms?  Yes  No

Describe: \_\_\_\_\_

2. Check all that apply:

- Erectile dysfunction       Difficulty with orgasm       Pain or swelling of the testicles       Frequent need to urinate at night  
 Impotence/erectile dysfunction       Premature ejaculation       Feeling of coldness or numbness in genitalia  
 Pain/Subtly of testicles

3. Do you get up at night to urinate?  Yes  No How often? \_\_\_\_\_

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?  
 \_\_\_\_\_

5. Have you sought Medical intervention for these problems? If so, when? \_\_\_\_\_  
 \_\_\_\_\_

6. What treatments have you tried for these problems and how successful have they been?  
 \_\_\_\_\_

**III. Medical History**

<i>Please check all that apply</i>	<i>Date Diagnosed</i>	<i>Date Diagnosed</i>
Diabetes	___ / ___ / ___	High Cholesterol
High Blood Pressure	___ / ___ / ___	High Blood Pressure
Thyroid Disease	___ / ___ / ___	Seizures
Cancer	___ / ___ / ___	Hepatitis
HIV	___ / ___ / ___	Others

**IV. Surgical History**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date \_\_\_\_\_  
 Date \_\_\_\_\_  
 Date \_\_\_\_\_

**V. Family History**

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

**VI. Medications / Supplements**

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (to medications, chemicals or foods):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**VIII. Nutrition**

1. Do you follow a special diet?  Yes  No If yes, how would you describe the diet?  
(ie Vegetarian, Vegan, Low Carb, etc.)

2. What do you eat on a "typical" day? \_\_\_\_\_

a) Breakfast \_\_\_\_\_

b) Lunch \_\_\_\_\_

c) Dinner \_\_\_\_\_

d) Snacks \_\_\_\_\_

e) Foods you tend to crave: \_\_\_\_\_

f) Foods you dislike: \_\_\_\_\_

**IX. Social History**

1. How much per day do you use of the following?

- a) Coffee, tea, soft drinks: \_\_\_\_\_
- b) Alcohol: \_\_\_\_\_
- c) Cigarettes, cigars, other tobacco: \_\_\_\_\_
- d) Other drugs: \_\_\_\_\_

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms?  
\_\_\_\_\_  
\_\_\_\_\_

7. In the past year, how many days have been significantly affected by your health? \_\_\_\_\_

8. How many days did you feel generally poor? \_\_\_\_\_

9. How many times were you in the hospital? \_\_\_\_\_

10. Please describe your current exercise regimen:  
Hours per week: \_\_\_\_\_ Activities: \_\_\_\_\_ [ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? \_\_\_\_\_

12. Do you awake feeling rested? [ ] Yes [ ] No      Do you feel you sleep well at night? [ ] Yes [ ] No

13. Who would you describe as your source of primary social support? (relationship to you)

**X. Other Information**

Please list and briefly describe the most significant events in your life:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH: CHECK ALL THAT APPLY**

**GENERAL**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _____

**SKIN & HAIR**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

**HECK & NECK**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _____

**EARS**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____

**EYES**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _____

**NOSE, THROAT, MOUTH**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

**CARDIOVASCULAR**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____

**RESPIRATORY**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: _____

**GASTRO-INTESTINAL**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: _____

**GENITO-URINARY**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: _____

**MALE**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: _____

**FEMALE**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: _____

**NEUROLOGICAL**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: _____

**PSYCHOLOGICAL**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: _____

**INFECTION SCREENING**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

**MUSCULAR-SKELETAL**

<u>Past</u>	<u>Current</u>	<u>Condition</u>
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain