COMPREHENSIVE ACUPUNCTURE EXAMINATION

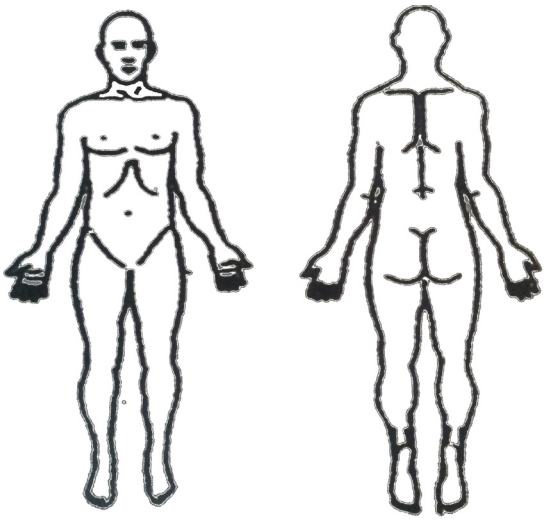
NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.

Name:_____

Date:_____Time:_____Birth Date:_____

Height:_____Weight:_____

Please mark your areas of pain on the diagram:



Front Back

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

What makes it better?_____

What makes it worse?_____

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

Medications/Drugs/Herbs you are currently taking:_____

_____

List of 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

☐ Heart trouble ☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Stroke

☐ Kidney or bladder trouble ☐ Gallstones ☐ Ulcers ☐ Jaundice

☐ High Blood pressure ☐ Chronic Fatigue ☐ Hepatitis

☐ Sudden Weight loss ☐ Sudden weight gain Other: _____

Family History: (Has anyone in 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 ☐ Boils ☐ Frequent skin rashes

☐ Changing moles or lumps (cysts/tumors) ☐ 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 at 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 ☐ Persistent cough ☐ Coughing blood ☐ Coughing phlegm

Sputum color _____ Consistency _____Other_____

Urine: Color_____ Amount_____Frequent Urination ☐ Day ☐ Night

☐ Strong smelling urine ☐ Hard to urinate ☐ Pain/burning when 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/elbow ☐ 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 or 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 ☐ Prostate trouble Other:_____

Appetite: ☐ Excessive appetite ☐ Poor appetite ☐ Appetite keeps changing

☐ Feel tired or weak if meal is missed ☐ Excessive thirst ☐ Never thirsty ☐ Other:_____

Specific food cravings? ☐ Yes ☐ No If yes, what?_____Other:_____

Digestion: ☐ Stomach gas ☐ Lower bowel gas ☐ Heartburn ☐ indigestion/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 groups"? ☐ Yes ☐ No

How many glasses of water do you drink a day?_____

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

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

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

Always add salt at the table? ☐ Yes ☐ No

Patient's Signature:_____