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Acupuncture & Herbal Medicine

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NAME		DATE	
AGE	DATE OF BIRTH	MARITAL STATUS	
HOME PHONE	WORK PHONE	E-MAIL ADDRESS	
HOME ADDRESS			
CITY		STATE	ZIP
CONTACT IN CASE OF EMERGENCY		RELATIONSHIP	PHONE

**MEDICAL HISTORY**

**CONFIDENTIAL**

MAJOR COMPLAINT/HEALTH PROBLEM:
HOW DID THIS CONDITON DEVELOP?
HOW LONG HAS THIS CONDITION PERSISTED?
PLEASE DESCRIBE ANYTHING THAT MAKES IT BETTER OR WORSE.
PLEASE DESCRIBE ANY TREATMENT YOU HAVE RECEIVED FOR THIS CONDITION IN THE PAST.
WHAT WERE THE RESULTS OF THE TREATMENT?

# MEDICAL HISTORY

**CONFIDENTIAL**

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING.

MEDICATION	STRENGTH	HOW MANY/DAY	FOR HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE LIST ANY SUBSTANCES YOU ARE ALLERGIC TO:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE LIST ANY HOSPITALIZATIONS OR SURGERIES YOU HAVE HAD.

DATE	HOSPITALIZATION/SURGERY
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE DESCRIBE ANY SIGNIFICANT TRAUMAS (CAR ACCIDENTS, FALLS, ETC.).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FAMILY HEALTH HISTORY	AGE	STATE OF HEALTH	HEALTH PROBLEMS
MOTHER			
FATHER			
SIBLINGS			

PLEASE LIST SIGNIFICANT HEALTH PROBLEMS AMONG YOUR GRANDPARENTS.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE CHECK ALL THAT APPLY.

- |  |                                     |                                       |  |
|--|-------------------------------------|---------------------------------------|--|
| <input type="radio"/> Arthritis          | <input type="radio"/> Cancer        | <input type="radio"/> Hepatitis       | <input type="radio"/> Seizures         |
| <input type="radio"/> Asthma             | <input type="radio"/> Diabetes      | <input type="radio"/> Hypertension    | <input type="radio"/> Thyroid Disease  |
| <input type="radio"/> Autoimmune Disease | <input type="radio"/> Gallstones    | <input type="radio"/> Kidney Stones   | <input type="radio"/> Venereal Disease |
| <input type="radio"/> AIDS               | <input type="radio"/> Heart Disease | <input type="radio"/> Rheumatic Fever |  |

PLEASE CHECK ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

- |  |  |   |   |
|--|--|---|---|
| <b>General</b>                               | <input type="radio"/> Sinus problems       | <input type="radio"/> Bloody stools         | <input type="radio"/> Oily skin             |
| <input type="radio"/> Chills                 | <input type="radio"/> Sores on lips        | <input type="radio"/> Black stools          | <input type="radio"/> Acne                  |
| <input type="radio"/> Low energy             | <input type="radio"/> Sores on tongue      | <input type="radio"/> Difficulty swallowing | <input type="radio"/> Brittle nails         |
| <input type="radio"/> Dizziness              | <input type="radio"/> Taste change         | <input type="radio"/> Poor appetite         | <input type="radio"/> Prematurely gray hair |
| <input type="radio"/> Allergies              | <input type="radio"/> Teeth problems       | <input type="radio"/> Heartburn/reflux      | <input type="radio"/> Dry, brittle hair     |
| <input type="radio"/> Fatigue                |  | <input type="radio"/> Hemorrhoids           | <input type="radio"/> Hair loss             |
| <input type="radio"/> Fevers                 | <b>Respiratory</b>                         | <input type="radio"/> Frequent indigestion  |   |
| <input type="radio"/> Excess thirst          | <input type="radio"/> Asthma               | <input type="radio"/> Stomachache           | <b>Neurological</b>                         |
| <input type="radio"/> Insomnia               | <input type="radio"/> Hay fever            | <input type="radio"/> Nausea                | <input type="radio"/> Fainting              |
| <input type="radio"/> Nervousness            | <input type="radio"/> Persistent cough     | <input type="radio"/> Vomiting              | <input type="radio"/> Convulsions           |
| <input type="radio"/> Spontaneous sweating   | <input type="radio"/> Coughing blood       | <input type="radio"/> Vomiting blood        | <input type="radio"/> Tremor                |
| <input type="radio"/> Night sweating         | <input type="radio"/> Bronchitis           |   | <input type="radio"/> Recent clumsiness     |
| <input type="radio"/> Lack of sweating       | <input type="radio"/> Phlegm production    | <b>Genitourinary</b>                        | <input type="radio"/> Vertigo               |
| <input type="radio"/> Weight loss            | <input type="radio"/> Shortness of breath  | <input type="radio"/> Dark urine            |   |
| <input type="radio"/> Weight gain            | <input type="radio"/> Difficulty inhaling  | <input type="radio"/> Blood in urine        | <b>Emotional</b>                            |
| <input type="radio"/> Aversion to heat       | <input type="radio"/> Difficulty exhaling  | <input type="radio"/> Cloudy urine          | <input type="radio"/> Irritability          |
| <input type="radio"/> Aversion to cold       |  | <input type="radio"/> Burning urination     | <input type="radio"/> Often feel angry      |
|  | <b>Cardiovascular</b>                      | <input type="radio"/> Scanty urine          | <input type="radio"/> Uncontrollable crying |
| <b>Head &amp; Neck</b>                       | <input type="radio"/> Chest pain           | <input type="radio"/> Profuse urine         | <input type="radio"/> Weepiness             |
| <input type="radio"/> Heaviness in the head  | <input type="radio"/> High blood pressure  | <input type="radio"/> Frequent urination    | <input type="radio"/> Sadness               |
| <input type="radio"/> Headache               | <input type="radio"/> Low blood pressure   | <input type="radio"/> Urgency to urinate    | <input type="radio"/> Forgetfulness         |
| <input type="radio"/> Phlegm in throat       | <input type="radio"/> Irregular heart beat | <input type="radio"/> Poor bladder control  | <input type="radio"/> Mental fogginess      |
| <input type="radio"/> Hoarseness             | <input type="radio"/> Poor circulation     |   | <input type="radio"/> Anxiety               |
| <input type="radio"/> Recurring sore throat  | <input type="radio"/> Swelling of ankles   | <b>Musculoskeletal</b>                      | <input type="radio"/> Unrestrained joy      |
| <input type="radio"/> Change in Vision       | <input type="radio"/> Varicose veins       | Pain, weakness, numbness in:                | <input type="radio"/> Much fear             |
| <input type="radio"/> Eye pain/strain        | <input type="radio"/> Chest distension     | Neck    Arms    Hands                       | <input type="radio"/> Troubling dreams      |
| <input type="radio"/> Red inflamed eyes      |  | Shoulders    Hips    Back                   |   |
| <input type="radio"/> Earache                | <b>Gastrointestinal</b>                    | Feet    Legs    Joints                      | <b>Men only</b>                             |
| <input type="radio"/> Ear discharge          | <input type="radio"/> Abdominal pain       | <input type="radio"/> All over weakness     | <input type="radio"/> Genital pain          |
| <input type="radio"/> Hearing loss           | <input type="radio"/> Bloating             | <input type="radio"/> All over pain         | <input type="radio"/> Impotence             |
| <input type="radio"/> Ringing in ears        | <input type="radio"/> Belching             | <input type="radio"/> Lack of strength      | <input type="radio"/> Genital sores         |
| <input type="radio"/> Nasal obstruction      | <input type="radio"/> Gas                  |   | <input type="radio"/> Lump in testicles     |
| <input type="radio"/> Nasal discharge        | <input type="radio"/> Constipation         | <b>Hair &amp; Skin</b>                      | <input type="radio"/> Penis discharge       |
| <input type="radio"/> Loss of sense of smell | <input type="radio"/> Diarrhea             | <input type="radio"/> Bruise easily         | <input type="radio"/> Nocturnal emission    |
| <input type="radio"/> Nosebleeds             | <input type="radio"/> Loose stools         | <input type="radio"/> Dry skin              | <input type="radio"/> Low sexual energy     |

# DIET AND HEALTH HABITS

Please give a general idea of your daily diet.

BREAKFAST
LUNCH
DINNER
SNACKS

Do you crave sweets and/or carbohydrates?  Yes  No

Do you exercise?  Yes  No

Other food cravings: \_\_\_\_\_

Type of exercise: \_\_\_\_\_

Do you eat regular meals?  Yes  No

How many times per week? \_\_\_\_\_

Please list the approximate times of your meals:

Occupation: \_\_\_\_\_

\_\_\_\_\_

Do you enjoy your work?  Yes  No

Are you hungry between meals?  Yes  No

Please list any occupational hazards you encounter such as

Are you sleepy after meals?  Yes  No

long work hours, high stress, chemical exposure, or heavy

Please give type and frequency of consumption of:

lifting. \_\_\_\_\_

Alcohol: \_\_\_\_\_

Please list any other concerns.

Caffeine: \_\_\_\_\_

\_\_\_\_\_

Recreational drugs: \_\_\_\_\_

\_\_\_\_\_

Please list all herbs and supplements you take regularly.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____