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Please complete the following form. All information on this form is **confidential** and will be seen only by our staff unless you give written authorization to release information.

First Name:_____ Middle Initial: __ Last Name:_____

Address:_____

City:_____ State: _____ Zip Code: _____

Phone: Day:_____Evening:_____ Cell: _____

E-mail address: _____

Gender: _____ Emergency Contact: _____

Emergency Contact Phone Number:_____

Primary Care Physician and telephone: _____

Date of Birth: ____/___/_____

Have you been treated by acupuncture before? ____

Main problems you would like help with:

_____

_____

How long ago did this problem begin:

_____

_____

To what extent does this problem interfere with daily activities such as work and sleep?

_____

_____

Have you been given a diagnosis for this problem?

_____
_____

Hospitalizations/surgeries/significant traumas:

_____
_____
_____

Allergies:

_____
_____

Medications taken in the last 2 months and reasons why:

_____
_____
_____

Describe your diet:

_____
_____
_____

How many hours of sleep do you get? ____
How many cups of caffeine do you drink per day? ____
How many glasses of water do you drink per day? ____
How much alcohol do you drink? ____
Do you smoke? ____ If so, how much? ____
Do you use recreational drugs? ____

Western Medical Diagnoses
(circle any that apply to you)

Diabetes	Hypertension	Cancer	Stroke
Heart Disease	Arthritis	Fibromylagia	Epilepsy/seizures
Multiple Sclerosis	Pacemaker	Allergies to Metals	Hepatitis B
HIV/AIDS	Hepatitis C	Tuberculosis	Thyroid Disease

Diagnostic Questions
(circle any that apply to you)

General

Fevers	Recent Weight Gain	Big Appetite
Sweats easily	Recent Weight Loss	Low Appetite
Never sweats	Strong Thirst	Always hungry
Chills	Likes Hot Beverages	Craves Sweet
Night Sweats	Likes Cold Beverages	Craves Salt
Poor sleeping	Sudden Energy Drop	Craves Spicy

Skin & Hair

Rashes	Ulcerations	Recent Moles
Itching	Eczema	Change of Skin Texture
Hives	Loss of Hair	Dry Skin
Dandruff	Pimples	Oily Skin
Psoriasis	Bruise Easily	Shingles
Cold Sores	Fungal Infections	

Head, Eyes, Ears, Nose & Throat

Sinus Problems	Nose Bleeds	Thrush/Candida
Difficulty Swallowing	Sore Throat	Dizziness
Headaches	Dry Mouth	Bleeding Gums
Ringing in the Ears	Eye Pain	Dry eyes
Hearing Problems	Itchy Eyes	Runny Nose
Post Nasal Drip	Sneezing	Blocked Ears
TMJ	Facial Pain	Jaw Clicks

Grind Teeth	Migraines	Color Blind
Concussions	Toothache	Cataracts
Glaucoma	Blurry Vision	

Respiratory

Shortness of Breath	Pain with Deep Breath	Phlegm
Cough	Chest Pain	Chest Tightness
Blood in Sputum	Bronchitis	COPD
Wheezing	Asthma (current)	Asthma (childhood)
Frequent Colds	Sleep Apnea	

Cardiovascular

High Blood Pressure	Fainting	Swollen Feet
Low Blood Pressure	Cold Hands or Feet	Irregular Heartbeat
Phlebitis	Heart Murmur	Swollen Hands
Blood Clots	Palpitations	

Gastrointestinal

Nausea	Gas	Bloating
Vomiting	Belching	IBS
Diarrhea	Constipation	Abdominal Pain
Blood in Stools	Black Stools	Indigestion
Hemorrhoids	Acid Reflux (GERD)	Bad Breath
Stomach Cramps	Rectal Pain	Chronic Laxatives

Genito-Urinary

Frequent Urination	Night Urination	Impotence

Low Sex Drive	Genital Sores	Genital Warts
Urgency	Hesitancy	Kidney Stones
Dribbling	Decreased Flow	Frequent UTI

Musculo-Skeletal

Ticks	Muscle Spasms	Neck Pain
Back Pain	Shoulder Pain	Elbow Pain
Wrist Pain	Hand Pain	Hip Pain
Knee Pain	Ankle Pain	Foot Pain
Tendonitis	Bursitis	Frozen Shoulder
Carpal Tunnel	Torn Ligaments	Atrophy
Nueropathy		

Reproductive and Gynecological

Pregancies # ____ Abortions # ____
Live Births # ____ Miscarriages #____

Age of first menses? _____
Period between menses? _____
Duration? ____

Heavy Flow	Light Flow	Clots
Painful Periods	Breast Tenderness	Mood Changes with Cycle
Cystic Breasts	Endometriosis	Vaginal Discharge
No Periods	Hysterectomy	Irregular Periods
Menopause	Vaginal Sores	PMDD

Do you practice birth control? ____
Are you pregnant? ___
Could you be pregnant? ___
Are you trying to get pregnant? ____

Neuropsychological

Seizures	Anxiety	Easily susceptible to stress
Poor Memory	Areas of Numbness	Lack of Coordination
Bad Temper	Loss of Balance	Inappropriate laughter
Depression	Always Worried	Frequent Waking

Have you ever been treated for psychological problems? ____
Have you ever considered or attempted suicide? ____

COMMENTS: please let us know what else you would like to discuss:
_____
_____
_____
_____