Acupuncture Physician

Past Medical History (include dates):

Name:		Phone:	Work:
Street:		Age: Height:	Weight:
City:		Sex:	
State:	Zip:	Occupation:	Referred by:
Physician:		Phone:	
Main Problem:			Onset:
Other Concurrent Therapies:		Emergency Contact:	Phone:

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis ___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other

Surgeries:

Significant Trauma: (auto accidents, falls, etc.)

Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods)

Medicines: taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses: (Chemical, physical, psychological, etc.)

Exercise:

Comments:

Average Daily Diet

Morning Afternoon Evening

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other

_____

Family Medical History: ___ Diabetes ___ Cancer ___ High Blood Pressure ___ Heart Disease ___ Stroke ___ Seizures ___ Asthma ___ Allergies ___ Alcoholism ___ Other _____

Notes_____

_____

_____

General

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep

☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo

☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen

☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily

☐ Cravings ☐ Localized weakness ☐ Poor coordination ☐ Change in appetite

☐ Sudden energy drop at _____ (time) ☐ Peculiar tastes/smells _____

☐ Strong thirst (cold/hot drinks) _____ ☐ Bleed or bruise easily (where) _____

_____

_____

Skin and Hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching

☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair

☐ Change in hair/skin texture ☐ Purpura ☐ Other hair or skin problem _____

_____

Head, Eyes, Ears, Nose, and Throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses
☐ Eye strain ☐ Eye pain ☐ Poor vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Blurry vision ☐ Baraches
☐ Ringing in ears ☐ Poor hearing ☐ Nose bleeds ☐ Sinus problems
☐ Mucus ☐ Dry throat ☐ Dry mouth ☐ Copious saliva
☐ Teeth problems ☐ Jaw clicks ☐ Grinding teeth ☐ Facial pain
☐ Gum problems ☐ Spots in eyes ☐ Recurrent sore throats _____ /month
☐ Sores on lips or tongue ☐ Headaches (where and when) _____
☐ Other head or neck problems

_____

Circulation

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other

_____

_____

Respiratory

☐ Cough ☐ Low blood pressure ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Difficulty in breathing when lying down ☐ Tight chest
☐ Production of phlegm _____what color _____ ☐ Other lung problems

_____

_____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea Bowel Movement:
☐ Gas ☐ Belching ☐ Black stools _____ Frequency
☐ Bad breath ☐ Rectal pain ☐ Hemorrhoids _____ Color
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____ Odor
☐ Pain or cramps ☐ Laxative use: _____ /week; type _____ _____ Texture/form

_____

_____

Genito-Urinary

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Unable to hold urine ☐ Kidney stones ☐ Venereal disease ☐ Impotency
☐ Wake up to urinate How often _____ /night; time _____ ☐ Other G/U problems

_____

_____

Pregnancy and Gynecology

☐ Number pregnancies ☐ Number births ☐ Premature births ☐ Miscarriages
☐ Age at first menses ☐ Period (days) ☐ Duration ☐ Irregular periods
☐ Flow (describe) ☐ Clots Last PAP _____ Last menses _____
☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps Menopause _____
☐ Birth control Type and duration _____ ☐ Changes in body/psyche prior to menstruation

_____

Musculoskeletal

☐ Neck pain ☐ Muscle pains ☐ Back pain (where) _____ ☐ Joint pain (where) _____

☐ Other joint or bone problems?

_____

_____

Neuropsychological

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion

☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed

☐ Treated for emotional problems ☐ Considered/attempted suicide

☐ Vaginal discharge

_____

_____

Comments

_____

_____

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_____

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_____