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MEDICAL HISTORY

Date:

PERSONAL INFORMATION

Full name:

Referred by:

Date of birth (MM/DD/YY):

Age:

Time of birth:

Place of birth:

Height:

Weight:

Marital status:

Occupation:

With whom do you live?

CONTACT INFORMATION

Address:

City:

ZIP:

Phone (cell):

Phone (home):

REASON(S) FOR VISIT

Why are you coming in for acupuncture? (What is your chief complaint, special stress)?

Details (hot/cold, pain/ache, moving/localized, sharp/dull, etc).

History:

MEDICAL TEAM & HISTORY

Name/Address of Primary Care Physician:

Names of other health care providers (Acupuncturist, Chiropractors, Therapists, etc.)

Surgeries:

Other hospitalizations:

Injuries/Accidents:

Other Diseases:

Medications (taken in the last month, prescription and non-prescription drugs with date and dosage if possible):

Known Allergies:

Significant medical tech reports (Labs, X-Ray, MRIs, Scans).

SYMPTOMS REVIEW

Directions: on the next pages, please circle or underline any of the following problems that have bothered you in the last 6 months. Comment in the space provided regarding symptoms frequency (e.g. daily, weekly), time of last occurrence, duration. This will create the opportunity to discuss with the doctor.

SYMPTOMS:		COMMENTS:
Head:	Headaches Dizziness	
Eyes:	Vision Problems	
Ears:	Poor Hearing Earaches Discharge Ringing in Ears	
Nose:	Poor sense of smell	
Mouth:	Pain Ulcers in mouth Bleeding gums Unusual dental problems	
Respiratory:	Cough Thick Sputum Wheezing Bloody Sputum Asthma Shortness of Breath Abnormal Chest X-Ray	
Heart:	Chest Pain or Pressure Heart Palpitations Exercise Intolerance	
Blood:	Previous history of anemia Tendency to bruise or bleed	
Gastrointestinal:	Poor appetite Heartburn Increased gas Nausea Vomiting Diarrhea Constipation Hernia Hemorrhoids	

SYMPTOMS:	COMMENTS:
Urinary:	Burning or pain with urination Change in quantity of urine Swelling of the ankles Urgency to urinate more History of venereal disease Need to urinate more at night Hesitancy Dribbling Loss of force to stream Abnormal color Urination with cough/sneeze
Reproduction:	Births
Men:	Impotence Premature ejaculation
Women:	Changes in your period Abnormal bleeding Pain with periods Vaginal discharge Vaginal pain Vaginal itching Bumps/sores in vagina
Endocrine:	Changes in hair or nails Intolerance to heat/cold Breast lumps Discharge from breast/nipples Adrenal Pituitary Thyroid
Skin:	Rash Itching Dryness Oily Pigment changes Acne Hives Changing moles or lumps
Neurological:	Anxiety/ Depression Abnormal Tremors/Shaking or Paralysis Seizures Numbness/Tingling of hands/feet Nerve pain/Neuralgia /Shingles
Musculoskeletal:	Arthritis Swelling of Joints Deformity / Muscular Cramps History of Joint Diseases Accidents Muscle Weakness Back Pain

SYMPTOMS:	COMMENTS:
General Health:	Abnormal Weight Loss/Gain Fatigue - Drowsiness Loss of feeling of wellbeing Unexplained level of chills Excess of energy Memory changes

MENSTRUATION

Regularity:

Days it lasts:

Heavy or light?

Other symptoms (depression/pain/changes caused/ menopause):

Last period began:

Number of pregnancies (easy/hard):

Pill? ☐ Never ☐ Yes, for _____ days / months / years

HABITS

Smoking:

How much of the following do you drink?

Coffee:

Alcohol:

Circle foods that you normally eat:

Hamburger Beef Lamb Pork Hot Dogs Ham Eggs Whole Milk

Chicken Fish Turkey Fruits Fresh Vegetables Bacon Avocados

Avocados Nuts Cheese Cake Chocolate Cookies Candy Salt

Butter Margarine Kefir Yogurt Ice Cream Brown Rice Millet Tofu

Beans Grains Fried foods Protein drinks Sugar Soda Black Tea

Have you been on a diet lately?

☐ No ☐ Yes

If yes, describe what type of diet:

List vitamins and mineral supplements presently taken:

List below a typical days meal:

Breakfast	Lunch	Dinner	Snacks

List meals in the last 24 hours:

Breakfast	Lunch	Dinner	Snacks

Select your favorite tastes: Sweet Salty Bitter Sour Spicy

EXERCISE

Circle activities that you normally engage in:

Walking Jogging Heavy gardening Yoga Pilates Swimming

Tai Chi Qi Gong Stretching Other:

SOCIAL

What type of work do you do or have you done?

Are you aware of any work related health hazards?

What kind of hobbies do you have?

Do you have any strong religious or philosophical feelings about your healthcare?

PERSONAL KNOWLEDGE

Strictly confidential

What type of person are you?

What do you think about yourself?

How do you feel about your body?

How do you feel about your emotions?

What is your favorite:

Color: | Climate: | Season: | Time of year:

How do you handle stress?

What is your general energy level? (physically, mentally, socially)

Any events in your life that have troubled you excessively in the past year?

Do you have any financial problems?

PERSONAL KNOWLEDGE

Strictly confidential

Do you enjoy your work?

How would you describe yourself emotionally–friendships, family, marriage, and depression?

Are you sexually active? Is it a problem for you?

What is your reaction to illness?

Do you have any special fears or anxieties?

How do you feel that your life is going?

Do you want to change anything about yourself?