

ACUPUNCTURE FOR ALL

PATIENT NAME _____

PLEASE CHECK CURRENT CONDITIONS

General

- ___ Difficulty falling asleep
- ___ Difficulty staying asleep
- ___ Fatigue in morning
- ___ Fatigue after meals
- ___ Aversion to cold
- ___ Aversion to heat
- ___ Frequent thirst
- ___ Excessive daytime sweating
- ___ Nighttime sweating

Muscles and Joints

- ___ Rheumatoid arthritis
- ___ Osteoarthritis
- ___ Muscle soreness
- ___ Muscle weakness
- ___ Muscle cramps
- ___ Numbness
- ___ Tingling
- ___ Paralysis

Head, Neck, & Back

- ___ Headaches / migraines
- ___ Neck stiffness/pain
- ___ Shoulder stiffness/pain
- ___ Knee pain
- ___ Back pain / Low, Mid, Upper

Eyes

- ___ Blurred vision
- ___ Poor night vision
- ___ Eye disease
- ___ Glasses

Ears, Nose, and Throat

- ___ Ear infection
- ___ Ringing in ear / tinnitus
- ___ Diminished hearing
- ___ Chronic sinus infections
- ___ Mouth / tongue sores
- ___ TMJ
- ___ Rhinitis / runny nose
- ___ Excessive phlegm

Skin

- ___ Itching
- ___ Hives
- ___ Acne
- ___ Eczema
- ___ Psoriasis
- ___ Dry skin/hair
- ___ Bruise easily
- ___ Hair loss

Respiratory

- ___ Chronic cough
- ___ Difficulty breathing
- ___ Wheezing / asthma
- ___ Frequent colds
- ___ Shortness of breath
- ___ Tight chest

Cardiovascular

- ___ Pacemaker
- ___ High blood pressure,
Last Reading _____
- ___ Low blood pressure
- ___ Palpitations
- ___ Chest pain or tightness
- ___ Heart murmur
- ___ Poor circulation
- ___ Cold hands
- ___ Cold feet
- ___ Phlebitis / Inflammation of vein
- ___ Blood clots
- ___ Spider veins/Varicose veins

Gastrointestinal

- ___ Bad breath
- ___ Poor Appetite
- ___ Excessive hunger
- ___ Food cravings
- ___ Recent weight gain/loss. Describe

- ___ Nausea / vomiting
- ___ Reflux / acid regurgitation
- ___ Gas / bloating
- ___ Loose stools / diarrhea
- ___ Constipation
- ___ Frequency of stools: _____
- ___ Laxative use
- ___ Hemorrhoids
- ___ Bloody or black stools
- ___ Pain or cramps stomach/intestines
- ___ Rectal pain

Genito-urinary

- ___ Pain on urination
- ___ Frequent urination
- ___ Unable to hold urine / dribbling
- ___ Wake to urinate
- ___ Kidney stone
- ___ Impotence

Neurological

- ___ Seizure Type? _____
- ___ Tremors
- ___ Dizziness / loss of balance

___ Poor memory

Tobacco, Food, Drink Habits

- ___ Smoke currently or previously. How
much/often? _____
- ___ Marijuana
- ___ Drug dependence
- ___ Drink alcohol
How much/often? _____

Female Reproductive

- ___ **Pregnant or possibly pregnant?**
- ___ Vaginal infections
- ___ Pain / itching of genitalia
- ___ Pelvic inflammatory disease
- ___ Very light/spotty bleeding
- ___ Menopausal symptoms:
 - ___ Hot flashes, # per day _____
 - ___ Night sweats, # per day _____
 - ___ Age at onset of menopause _____
- ___ Breast lumps
- ___ Clotting during menses
- ___ Uterine fibroids
- ___ Number of live births:
Children's ages: _____
- ___ History of Miscarriages
- ___ Irregular menstrual periods
- ___ Painful menstrual periods
- ___ Premenstrual syndrome (PMS)
- ___ Excessive bleeding
- ___ Length of cycle in days _____
- ___ Length of bleeding in days _____
- ___ Bleeding between periods
- ___ Date last period began: _____

Psychological

- ___ Depression /Mild, Moderate, Severe
- ___ Anxiety /Mild, Moderate, Severe
- ___ Irritability
- ___ Considered/Attempted Suicide
- ___ Seeing a therapist

Other

- ___ Hepatitis Type? _____
- ___ Infectious diseases _____
- ___ Occupational Hazards _____
- ___ Metal joints/implants _____
- ___ History of Cancer _____
- ___ Undergoing Cancer Treatments _____
- ___ Autoimmune Disorder: _____
- ___ Hypothyroid/___Hyperthyroid
- ___ Diabetes Type? _____

Please List Current Prescription Medications and Condition

Please List Surgeries and Traumas