

COMPREHENSIVE ACUPUNCTURE EXAMINATION

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.

NAME _____ Date _____ Time _____ Account No. _____

Birth Date: _____ Height _____ Weight _____

Major Complaint/s _____

Other Complaints: _____

Date of onset (when you first noticed your problem)? _____

Pain is: Minimal Slight Moderate Severe

How long have you had this condition? _____

Have you had this in the past? Yes No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: Getting worse Constant Comes and Goes

Medications/Drugs/Herbs you are currently taking: _____

List Surgeries/Operations you have had and dates: _____

Date of your last physical examination _____ By whom? _____

MEDICAL HISTORY: (Do you have or have you ever had): Arthritis Asthma Anemia Heart trouble Cancer

Diabetes Epilepsy Stroke Kidney or bladder trouble Gallstones Ulcers High blood pressure

Chronic fatigue Hepatitis Jaundice Sudden weight loss Sudden weight gain

Other: _____

FAMILY HISTORY: (Has any member of your family had any of the above)? Yes No If yes, which member and what did they have? _____

ENERGY LEVEL: High (Time of day) _____ Low (Time of day) _____

STRESS: None Moderate Severe What causes it? _____

SWEATING: Night sweats Rarely sweat Excess sweating _____

CIRCULATION: Feelings of Hot Cold What area? _____

Bleed easily Cold limbs Other: _____

SKIN: Dry Itchy Moist/clammy Burning Changing moles or lumps (cysts/tumors) Boils

Frequent skin rashes Acne Hair loss/thinning Dry scalp Skin puffy/wrinkled

Bruises easily (black and blue spots) Hives Other: _____

SCARS: (List ALL scars from accidents or surgeries) _____

SLEEP PROBLEMS: Trouble falling asleep Trouble staying asleep Restful Excess dreaming

Other: _____ How many hours do you sleep a night? _____

HEAD: Headaches (what area?) _____ Dizziness Memory loss Loss of balance

Other: _____

EYES: Eye pain Dry eyes Blurred vision Darkness under eyes Other: _____

EARS: Poor hearing Earaches Ear discharge/infections Ringing/buzzing in ears

Other: _____

NOSE: Frequent nose bleeds Sinus trouble Frequent colds Other: _____



THROAT: Sore throat Hoarseness Difficulty swallowing Jaw problems Teeth/gum problems Swollen tongue

Other: _____

CHEST: Hard to breathe Wheezing Shortness of breath Mucus rattles when breathing Trouble breathing at night
 Pain/pressure in chest Palpitations Persistent cough Coughing blood Coughing phlegm

Sputum color _____ Consistency _____

Other: _____

BLOOD PRESSURE: High Low Do not know

BOWELS: Diarrhea Constipation Bloody stools Black stools Mucus in stools Hemorrhoids

Lower bowel gas Stools have foul odor Colon problems Number of bowel movements a day _____

Other: _____

URINE: Color _____ Amount _____ Frequent urination Daytime At night

Strong smelling urine Hard to urinate Pain or burning on urinating Blood in urine

Frequent infections Water retention Other: _____

MUSCULOSKELETAL: Pain in: Neck Shoulder Between shoulders Arms/hands Hip Knee

Fingers Big toe Upper back Mid back Lower back Bones sore/painful Loss of grip

Swollen knees/elbows Leg cramps at night Weakness in legs Weak ankles Stiff all over

Tingling in feet Muscle spasm/cramps Loss of feeling in hands/feet Painful joints Bursitis

Other: _____

NEUROLOGICAL: Nervousness Depressed Easily angered Easily irritated Frequent crying

Worry/Anxiety Mood swings Memory confusion Poor concentration Suicidal Tremors

Numbness/tingling in limbs Poor coordination Muscle weakness Feel weak and shaky Seizures

Neuralgia (nerve pain) Shingles Other: _____

FEMALES: Pregnant? yes No Last monthly period _____ Last PAP test _____

Form of birth control: None Pill Other: _____

Age started menstrual cycle _____ Age stopped _____ Menstrual pain Low backache

Irregular Clotting Heavy bleeding Light scanty bleeding Color _____

Water retention Mood changes Miss periods Low or no sex drive Painful breasts Hot flashes

Food cravings Other: _____

Discharges: Yellow Thick White Odor Itching Liquid Other: _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____

No. Cesareans _____ Operations: Cervix Uterus Ovaries Other: _____

MALES: Low sexual drive Lack of sexual drive Impotence Ejaculation causes pain Discharges

Pain or burning while urinating Premature ejaculation Prostate trouble Other: _____

APPETITE: Excessive appetite Poor appetite Appetite keeps changing Feel tired or weak if a meal is missed

Excessive thirst Never thirsty Other: _____

Specific food cravings? Yes No If yes, what? _____

Other: _____

DIGESTION: Stomach gas Lower bowel gas Heartburn Burning/belching Stomach pain

Stomach cramps Nausea Vomiting Bad breath Sores in mouth Weight gain Weight loss

Bitter/sour taste in mouth Abdominal bloating How long after eating? _____

Food allergies? yes No If yes, to what? _____

NUTRITION: List some of your favorite foods _____

Do you: Skip breakfast Eat a snack Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? Yes No How often? _____

Do you plan your meals according to the "Four basic food groups"? Yes No

How many glasses of water do you drink a day? _____ Filtered Bottled

