

HEALTHY LIVING ACUPUNCTURE AND WELLNESS

Patient Name _____

Date _____

General Information

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Referred By _____

Date of Birth _____ Occupation _____ Married Divorced Widowed Single

E-Mail _____ Receive email communications? Yes No

Emergency Contact _____ Relationship _____ Phone _____

Family Physician _____ Phone _____

Have you had Acupuncture or Oriental medicine before? Yes No

What was your experience? Very good Good No Change

Are you presently under a doctor's care? Yes No Who and what for? _____

Are there any other therapies that you are involved in? Yes No Who and what for? _____

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities? Work Sitting Relationships Recreation
 Sleep Standing Social Life Bending
 Walking Emotional Sexually Stretching
 Other: _____

What have you done about this? _____

What (functional) limitation, movement, and/or activity can you not do? _____

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma and when it occurred: _____

List exercise and sport activities you have been or are currently involved in: _____

Medical History

Do you have any allergies? Yes No If so, to what? _____

Do you take any medication? Yes No If so, what types and how often? _____

Do you take any pain medication? Yes No If so, what types and how often? _____

Do you take supplements? Yes No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

- | | | | | |
|---------------------------------------|--|---|--|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug reaction | <input type="checkbox"/> Mental breakdown | <input type="checkbox"/> Gonorrhea/Herpes | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Jaundice | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypo/Hyper thyroid |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Parasites | <input type="checkbox"/> Cancer | <input type="checkbox"/> Premature graying |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Obesity | <input type="checkbox"/> Syphilis | <input type="checkbox"/> High/Low blood pressure | |

Do you sleep well? Yes No

Do you dream? Yes No

Do you have a high point during the day? Yes No When? _____

Do you have a low point during the day? Yes No When? _____

Female / Male Concerns

Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you been pregnant? Yes No Birth control? Yes No How long? _____

PMS Clotting Vaginal sores Vaginal pain Other _____

Testicle pain Penis pain Penis Sores Discharge Premature ejaculation Nocturnal emission

Impotence Other _____

Signs / Symptoms

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Abdominal pain/distention | <input type="checkbox"/> Cough | <input type="checkbox"/> Headache | <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Cough Blood | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mucus in stools | <input type="checkbox"/> Short temper |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Muscle cramps/pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> Hiccup | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Sinus pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Skin fungal infection |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Dry throat/mouth | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Night sweat | <input type="checkbox"/> Spots in eyes |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Earaches | <input type="checkbox"/> Intestinal pain/cramps | <input type="checkbox"/> Numbness | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Irritable | <input type="checkbox"/> Odorous stools | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Bowel Movements Frequency _____ | <input type="checkbox"/> Eye pain/strain | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Swollen glands |
| | <input type="checkbox"/> Excessive phlegm Color _____ | <input type="checkbox"/> Itchy skin | <input type="checkbox"/> Peculiar tastes | <input type="checkbox"/> Teeth/gum problems |
| <input type="checkbox"/> Breast lump/pain | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Upper back pain |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Fever | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Limited range motion | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Gas/Belching | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Wake to urinate |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Rash | <input type="checkbox"/> Weight loss/gain |
| Other: _____ | <input type="checkbox"/> Migraine | <input type="checkbox"/> Redness of eyes | <input type="checkbox"/> Wheezing | |

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

No Pain Moderate pain Severe pain Terrible pain

Sleeping

No problem Disturbed Very disturbed Cannot sleep

Work – Can do:

Usual work 50% of work 25% of work Cannot work

Frequency of pain

25% of time 50% of time 75% of time 100% of time

Travel

No problem Moderate pain on trips Severe pain

Recreation – Can do:

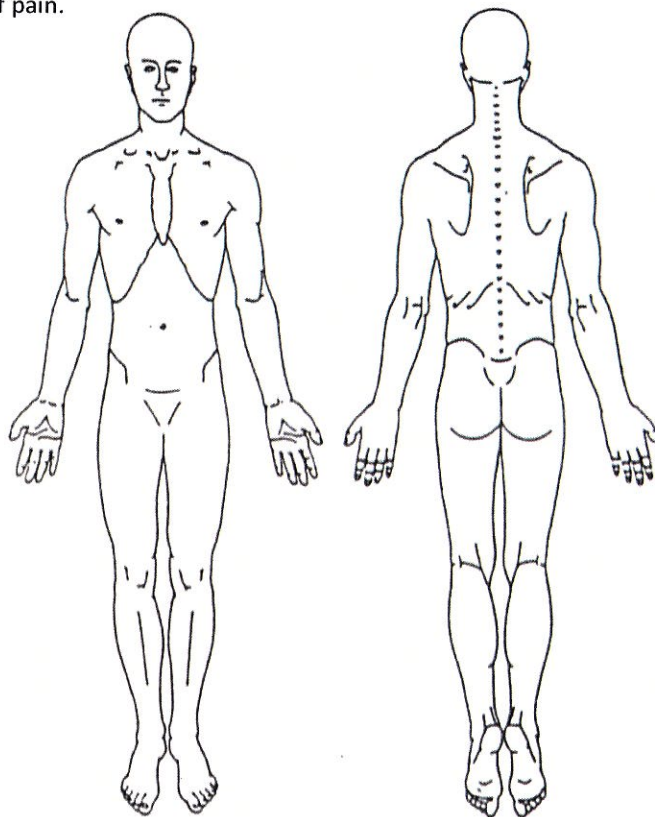
All activities Some activities No activities

Walking

Can walk fine Pain after ½ mile Cannot walk

Sitting

No pain sitting Some pain while sitting Cannot sit



Pain Key

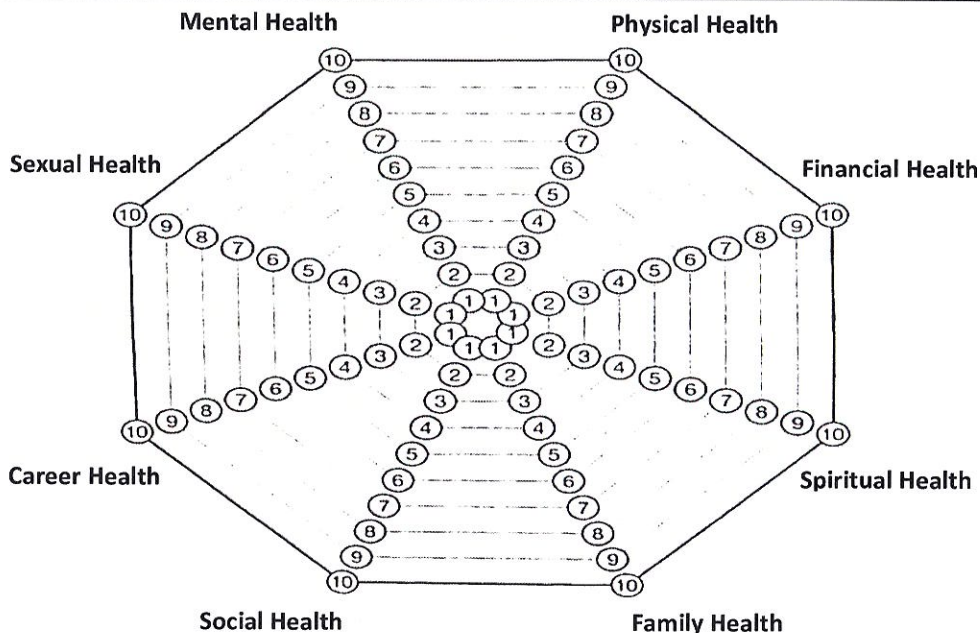
Ache	Numbness	Pins & Needles	Burning	Stabbing
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Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, If you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

