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? _____

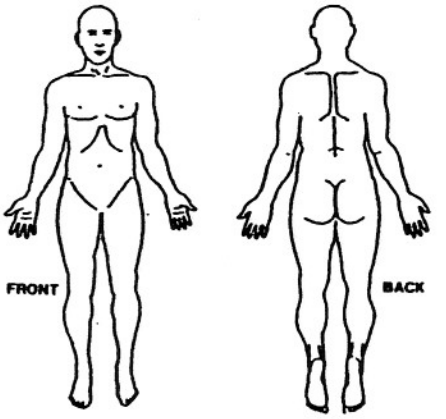
Have you had this in the past? ☐ Yes ☐ No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and Goes

PLEASE MARK YOUR AREAS OF PAIN



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 ☐ Persistant 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

Do you use: Alcohol? ☐ Yes ☐ No Amount per week _____ Type _____

Tobacco? ☐ Yes ☐ No Packs per day _____ How many years _____

DO YOU:

Eat raw fruits or vegetables at least twice a day? ☐ Yes ☐ No

Eat green or yellow vegetables at least twice a day? ☐ Yes ☐ No

Eat frequently between meals? ☐ Yes ☐ No

Chew your food thoroughly before swallowing it? ☐ Yes ☐ No

Drink juice, milk or other drinks instead of water when thirsty? ☐ Yes ☐ No

Always add salt at the table? ☐ Yes ☐ No

Eat meat or dairy products 2 or more times a day? ☐ Yes ☐ No

Eat the same foods almost every day? ☐ Yes ☐ No

Eat when you are not hungry? ☐ Yes ☐ No

Eat until you feel full? ☐ Yes ☐ No

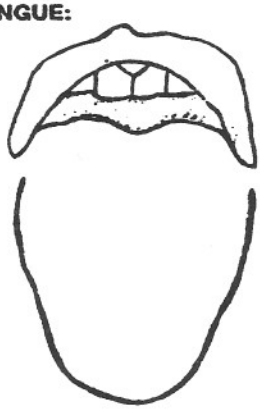
Occasionally go on a "crash" diet? ☐ Yes ☐ No

Patient's Signature _____

DO NOT WRITE BELOW THIS LINE

EXAMINATION

TONGUE:



Color _____

Coat _____

Body _____

PULSE

	RIGHT	LEFT

GENERAL CHARACTER _____

TEMPERATURE: _____

BLOOD PRESSURE: _____

APPEARANCE: ☐ Excellent ☐ Good ☐ Fair ☐ Well-nourished ☐ Undernourished ☐ Debilitated ☐ Thin ☐ Husky ☐ Overweight _____

MOVEMENT: ☐ Guarded ☐ Slow ☐ Impaired ☐ Needs assistance ☐ Deformity _____

SKIN COLOR: _____ FACIAL COLOR: _____ EYES: _____

AREA CLIMATE: Body odors _____ Smell _____

ABDOMEN (by palpation): ☐ Organ swelling ☐ Masses ☐ Hernia ☐ Pain _____

ABDOMINAL REFLEX(es): _____

ASSESSMENT/EVALUATION/FINDINGS: (Internal, emotional, dietary, channel disorders, trauma, constitution, inactivity, overworked, etc.)

EIGHT PRINCIPLES: (Yin/Yang, Internal/External, Hot/Cold, Deficient/Excess) _____