ALL INFORMATION IS CONFIDENTIAL and is used in determining the best treatment plan for you. If you have any questions, please feel free to ask.

PATIENT INFORMATION

Name: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

○ Single ○ Married ○ Divorced ○ Separated
○Widowed ○Partnered

Occupation: _____ Date of Birth: _____

Height: _____ Weight: _____ Age: _____

Emergency Contact: _____

Home Phone: _____ Other Phone: _____

Relationship to You: _____

Have you received acupuncture before? Yes _____ No _____

If yes, with whom? _____

For what condition? _____

What are your most important health concerns? Please list in order of importance:

1.		Date of Onset?	
2.		Date of Onset?	
3.		Date of Onset?	
4.		Date of Onset?	
5.		Date of Onset?	

What are your health goals?

_____

_____

_____

SYMPTOM SURVEY

Please review the following symptoms and mark an X in the appropriate column.

	Seldom	Frequent		Seldom	Frequent
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		

How is your energy level today?	**Very low**	**Low**	**Medium**	**Very good**	**Extremely good**

HEALTH HISTORY

Primary Physician: _____

Physician's Phone: _____ Date of last physical exam: _____

Please list any hospitalization and/or surgeries

Hospitalization / Surgery	Date	Reason

Please list any accidents and/or injuries:

Accident / Injury	Date	Relation to Health

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for Taking	Taking Since

Please, continue at the reverse page, if you need more space.

About how many courses of antibiotics have you taken over the past 10 years? _____

List any allergies or food sensitivities: _____

_____

Please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc):

Name	Dosage	Reason for Taking	Taking Since

Do you have a pacemaker? Yes _____ No _____

Are there any issues of physical / sexual / emotional abuse
that you would like to discuss? Yes _____ No _____

HEALTH HISTORY

Please indicate if you are taking any of the following:

- ○ blood thinners (e.g. warfarin, Coumadin)
- ○ pain relievers (e.g. Tylenol, aspirin.)
- ○ sleeping aids
- ○ thyroid medication
- ○ laxatives
- ○ lithium
- ○ other tranquilizers/sedatives
- ○ diet pills (e.g. diuretics, appetite suppressants)
- ○ cortisone or other steroids
- ○ antacids (e.g. Tums, Prevacid)

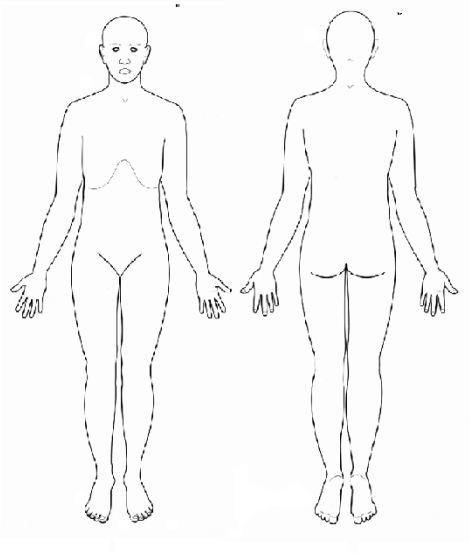
Do you have a bowel movement every day? Yes ○ No ○

Number of bowel movements per day? _____ Or per week? _____

Are your bowel movements (check all that apply):

- ○Well formed
- ○ Soft
- ○ Ribbon-like
- ○ Loose
- ○ Containing undigested food
- ○ Containing blood
- ○ Bad smelling
- ○ Burning
- ○ Burning/heaviness in rectum
- ○ Incomplete
- ○ Hard to clean up after
- ○ A struggle

Using the appropriate letters, note any areas of pain on the diagram:



D = Dull
S = Sharp
N = Numbness
T = Tingling
B = Burning
R = Radiating
A = Ache
X = other: _____

FAMILY HISTORY

Please indicate any significant illness you or a blood relative (grandparent, parent, sibling) have had:
_____ I am adopted

	You	Which Relative?		You	Which Relative?
Cancer			Diabetes		
Emotional Disorders			Heart Disease		
High Blood Pressure			Seizures		
Rheumatic Fever			Hepatitis		
Arthritis			Tuberculosis		

LIFESTYLE HISTORY

Please indicate the use and frequency of the following:

	Now	Past	How Much		Now	Past	How Much
Water				Recreational Drugs			
Soda Pop				Alcohol			
Coffee/Black Tea				Tobacco			

Do you exercise? _____ How many times a week? _____

What type of exercise? _____

Please describe your typical diet:

Breakfast:	
Lunch:	
Dinner:	
Snacks:	

meals per day: _____ Do you eat at regular times each day? _____

snacks per day: _____ How often do you eat out (or order in)? _____

I eat the following diet (please circle) vegetarian vegan kosher

Are there other restrictions to your diet? _____

What is your average stress level (*1 is lowest, 10 is highest*)? _____

What is your average energy level (*1 is lowest, 10 is highest*)? _____

At what time of day is your energy typically at its best? _____ At its worst? _____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Significant Other	○	○	○	○	○
Family Relations	○	○	○	○	○
Friendships	○	○	○	○	○
Self Image	○	○	○	○	○
Sex	○	○	○	○	○
Work	○	○	○	○	○
Exercise	○	○	○	○	○
Spirituality	○	○	○	○	○

How much change are you willing to/able to make at this time to improve your health? (Please circle)

Minimal Some Complete

FOR MEN

Date of last prostate exam: _____ PSA results: _____

Prostate exam results / diagnosis: _____

Frequency of urination -- Day Time: _____ Night Time: _____

Color of Urine (please circle): Colorless Light Yellow Dark Yellow Reddish

Urine is cloudy: Yes No Urine has an odor: No Yes like: _____

Please mark an X in the appropriate column if you experience any of the following:

	Seldom	Frequent		Seldom	Frequent
Delayed Urine Stream			Increased Libido		
Dribbling Urine			Decreased Libido		
Urinary Incontinence			Discharge/Sores		
Urinary Retention			Premature Ejaculation		
Testicular Masses			Inability to Ejaculate		
Testicular Pain			Difficulty Achieving Erection		
Groin Pain			Difficulty Sustaining Erection		
Hernia			Impaired Fertility		
Back Pain			Rectal Dysfunction		

Are You Sexually Active? Yes No

List any known STDs: _____

Is there anything else you would like us to know? _____

_____

_____

_____

FOR WOMEN

Date of last OB/GYN exam:: _____ Are you pregnant now? Yes No

Age of first period: _____ Age of last period (post menopause): _____

Number of days between periods: _____ Number of days of bleeding: _____

The bleeding is: ○ Heavy ○ Moderate ○ Light ○ Spotting Only

Menstrual Blood Color (check all that apply): ○ Pale Pink / Red ○ Red ○ Bright Red ○ Dark Red ○ Dark Red / Brown ○ Black ○ Dark Purple

Number of pads/tampons used: ___ day 1 ___ day 2 ___ day 3 ___ day 4 ___ day 5 ___ day 6+

How often do you change your pad/tampon? ○ Every hour or less ○ Every 2 hours ○ Every 4 hours ○ I don't really need to change it, but I do for hygiene
Other:_____

On your heaviest day, which do you use? ○ Regular ○ Super ○ Super Plus

Do you bleed between periods? Yes No

If yes, bleeding is: ○ Heavy ○ Moderate ○ Light ○ Spotting Only

Periods are painful: ○ Before Period ○ During Period ○ After Period ○ N/A

Pain severity: ○ Mild ○ Moderate ○ Severe ○ N/A

Location of pain: ○ Low Abdomen ○ Low Back ○ Thighs ○ Other:_____

The quality of the pain is (check all that apply): ○ Cramping ○ Stabbing ○ Aching ○ Dull ○ Burning ○ Constant ○ Comes & Goes ○ Bearing Down

Do you pass clots during your period? (please circle) yes no

Clot Color: ○ Bright Red ○ Dark Red ○ Brownish ○ Black ○ Dark Purple ○ Sticky

On average, the clot size is: ○ Small & Stringy ○ Small & Round ○ Dime Sized ○ Egg Yolk Sized ○ Larger Than an Egg Yolk

Do you feel pain when you pass the clots? (please circle) Yes No N/A

Do you feel better after passing the clots? (please circle) Yes No N/A

Please review the following symptoms related to your period and mark an X in the appropriate column.

FOR WOMEN

	Seldom	Frequent		Seldom	Frequent
Headaches			Swollen or Painful Breasts		
Cravings			Mood Swings		
Nausea			Increased Appetite		
Constipation			Decreased Appetite		
Diarrhea			Insomnia		

Have your periods changed since they started? Yes No

When? _____

Why? _____

Total Number of Pregnancies: _____ Number of Live Births: _____

Number of Miscarriages: _____ Number of Terminations: _____

Are You Sexually Active? Yes No

List any known STDs: _____

Current Type of Birth Control: _____ Used for How Long? _____

What other types of birth control have you used in the past? _____

Do you experience any sexual difficulties? (please describe) _____

Please mark an + in the appropriate column

if you have experienced any of the following	Seldom	Frequent	If you have being diagnosed		
Yeast Infections			Endometriosis		
Vaginal Discharge/Odor			Ovarian Cysts		
Urinary Tract Infections			Fibrocystic Breasts		
Pain/Itching of Genitalia			Breast Cancer		
Genital Lesions/Discharge			Uterine Fibroids		
Breast Lumps			Herpes		
Nipple Discharge			HPV (Human Papilloma Virus)		
Abnormal Pap Smear			Hysterectomy		
PID (Pelvic Inflammatory Disease)			Uterine Prolapse		

Is there anything else you would like us to know? _____