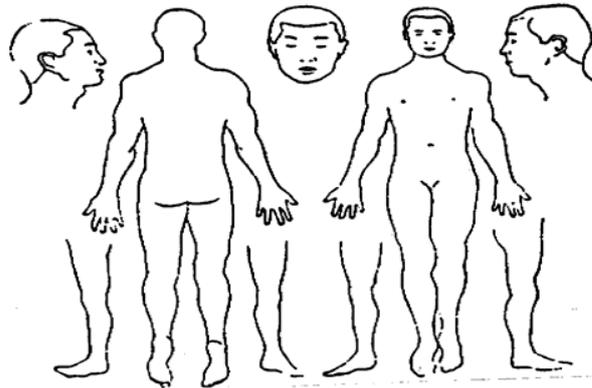


Please indicate where your symptoms are occurring & indicate any pain, tenderness, burning, numbness, tingling, stiffness, swelling, bruising, open wounds, scars, etc.



Allergies/Intolerances: (Nuts, oils, food, chemical, environmental, drugs, etc.) _____

Medications: (names & dosages) Please attach an additional page if necessary. _____

Vitamins/Supplements/Herbs: _____

Exercise

Days per week	Length of workout	Type of Activity
---------------	-------------------	------------------

Diet

Meals per day	Snacks	Caffeinated Drinks	Alcohol/week
---------------	--------	--------------------	--------------

Personal History Please check any conditions you have now or have had in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Whooping Cough/TB |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Emphysema |

Family Medical History F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather)

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes ____ | <input type="checkbox"/> Seizures ____ | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure __ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer ____ | <input type="checkbox"/> Asthma ____ |

Please take your time and **check** if you have had any of these items listed below in the last **year** or you feel they are a significant part of your medical history.

General

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Prefer Hot or Cold drink | <input type="checkbox"/> Cold hands and feet |

Skin and Hair

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |

Head, Eyes, Ears, Nose, Throat

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks/TMJ | <input type="checkbox"/> Headaches |
| | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Excess saliva | <input type="checkbox"/> Head other _____ |

Cardiovascular

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Dizziness | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Excess Production of phlegm...Color _____ | |

Gastrointestinal

Frequency of Bowel Movements _____

- | | | | | | | |
|--|---|--|--|-------------------------------------|--|--|
| <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Dry | <input type="checkbox"/> Soft | <input type="checkbox"/> Mucous | <input type="checkbox"/> Incomplete | <input type="checkbox"/> Undigested Food | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | | | |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool | | | |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids | | | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps | | | |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive | | |
| | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | | | | |

Genito-Urinary

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ | | | <input type="checkbox"/> Excessive libido |

Gynecological/Reproductive (please answer what you feel comfortable answering)

- | | | |
|--|--|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses _____ |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses _____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Number of pregnancies _____ |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> PMS | <input type="checkbox"/> Number of live births _____ |
| | <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of miscarriages _____ |
| | | <input type="checkbox"/> Number of abortions _____ |

I _____

give my consent to treatment, Date _____ Signature _____

Musculoskeletal

- Neck pain
- Knee pain
- Hip pain
- Back pain Low___ Middle___ Upper___
- Shoulder pain
- Sprains/Strains
- Muscle pain
- Hand/wrist pain
- Sciatica
- Muscle weakness
- Bursitis
- Carpal Tunnel
- Foot/ankle pain
- Tendonitis
- Rotator Cuff

Neuropsychological

- Seizures
- Anxiety/Panic attacks
- Nervousness
- Numbness
- Loss of balance
- Bad temper
- ADD/ADHD
- Tics
- Vertigo/Dizziness
- Easily susceptible to stress
- Manic Depression
- Areas of numbness
- Seasonal Affective Disorder
- Irritable

I _____, understand that a change or cancellation of my appointment requires a minimum of 24 hours notice or a cancellation fee will be charged. No shows will receive a bill for 100% of the consultation fee. Date: _____, Signature _____

The patient must inform the practitioner if the patient has a severe bleeding disorder, is pregnant, or has a pace maker prior to any treatment.

Potential risks include, but not limited to, temporary pain, bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include broken needle, dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.