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? _____

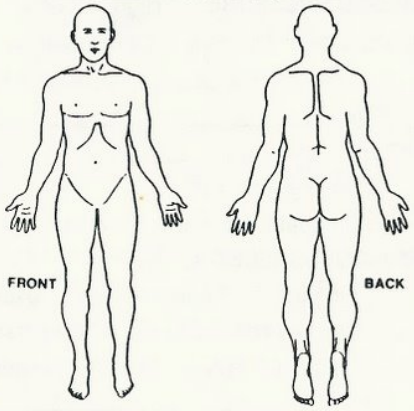
Have you had this in the past? ☐ Yes ☐ No When? _____

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: _____

_____