DATE __/__/____ **[PLEASE PRINT LEGIBLY ~ THANK YOU]**

Contact information: NAME _____**DOB** __/__/____
Email address _____
Street address _____
City _____State _____Zip _____
Phone #s (work, home, mobile,other) _____
_____
In emergency notify: _____
Relationship _____ Contact info: _____

If minor: Guardian name_____
Guardian's relationship to minor_____

Other:
Physician_____phone #_____
May I thank someone for your referral?_____
How did you find out about me?_____
Have you been treated with acupuncture before?_____
Did it help?_____
What was being treated?_____
Previous acupuncturist(s)_____

Family History Chart please complete including Cancer, Diabetes, Heart Disease, Stroke, Hi Blood Pressure, Thyroid Disorder and any other major illness or disorders

Family member	major illness	if deceased, age & cause
Mother		
her mother		
her father		
Father		
his mother		
his father		
Sibling # 1		
Sibling # 2		
Child # 1		
Child # 2		

Personal Medical History

Chief Complaint: [1-3 **primary** health concern(s) today] _____
_____

Please check all that apply to **your own health**:
- Allergies to drugs or latex (specify) _____
- Diabetes (I or II)
- Heart Disease, please specify_____
- Bleeding or bruising (easily) tendency
- High Blood Pressure (treated or untreated?)
- Rheumatic Fever
- Thyroid Disfunction
- Seizures or Epilepsy
- Hepatitis
- HIV
- Surgeries, please specify ALL with date _____
_____
_____
- Significant trauma(s) if any, please specify with date _____
_____
_____

Lifestyle & Miscellaneous: **[More space on last page if needed]**
Diet: Caffeine drinks _____ average cups/day Water_____ average cups/day
Vegan? Y/N; Vegetarian? Y/N _____(type); Dairy-free? Y/N; Gluten-free Y/N
Meatless meals _____ average #/week; Veggies _____ average servings/day
Dairy (cheese, ice cream, creamy sauces & dressings) _____ average servings/day
Do you usually eat spicy food? Y/N Eating out _____ average # meals/week
Allergies: _____ Preferences? Organic/Non-GMO? Y/N
Other remarks and additional dietary information: _____
_____
Please describe a typical daily diet, being as specific as possible:
Morning _____
Afternoon _____
Evening _____
Snacks _____
Rx/Medications/Supplements: _____
Vitamins & Minerals: _____
Herbs (list any you've taken) _____
Have you ever taken Chinese Herbs? Y/N; What was treated? _____
Exercise:_____minutes/week (average); Type: (ex. yoga) _____
Meditation? (Never, Rarely, Occasionally, Often, Regularly)
Breathing exercises? (Never, Rarely, Occasionally, Often, Regularly)
Cigarettes? _____pks/day for _____yrs Alcohol? _____ servings/week
Recreational Rx?_____ May effect treatment; cessation treatments available.

Circle your preference, **if any**:
1. hot **or** cold drinks
2. hot **or** cold weather
3. morning **or** nighttime
4. sweet **or** salty **or** bitter **or** sour **or** spicy (circle all that apply)

System History Review: please indicate your health HISTORY **and** current issues:

General

- poor appetite
- excessive appetite
- change in appetite
- cravings (specify) _____
- weight gain (_____# in _____ mos.)
- weight loss (_____# in _____ mos.)
- strong thirst
- sleep well
- unable to go to sleep (insomnia)
- unable to stay asleep (insomnia)
- fitful or dream disturbed sleep
- waking unrested
- heavy sleeper
- often sleepy (somnolence)
- sweat easily
- night sweats
- hot flashes; hot chest or head
- sweaty palms
- little or no sweat, even with exercise
- fever
- chills
- cold abdomen
- cold back
- cold hands/feet
- sudden energy drops
- sudden surges in energy
- fatigue, weakness
- tired, fatigue or bloating after eating
- abdominal pain or bloating
- rib or side pain
- unusual tastes in the mouth, specify if you can, please_____

Skin Nails & Hair

- eczema
- hives
- ulcerations
- bruising easily
- changes in or concerning mole (color, size, texture)

- dry brittle cracking or peeling nails
- ridged nails
- dry skin
- excessive or sudden hair loss
- premature graying of hair
- changes in hair, nail or skin texture, please specify_____
- other, please specify_____

Head, Eyes, Ears, Nose & Throat

- headaches
- migraines
- dizziness
- concussions
- poor hearing
- tinnitus (ringing ears)
- sinus problems
- frequent nosebleeds
- nasal polyps
- grinding of teeth
- jaw clicks
- TMJ
- dry or chapped lips
- sores on lips or tongue
- excessive dental cavities
- excessive gum bleeding
- facial pain
- facial numbness
- poor vision
- night blindness
- cataracts
- blurred vision or floaters
- excessive tearing
- other eye problems
- sore or itchy throat
- recurrent sore throats
- dry throat/cough
- dry mouth
- dry mouth with no thirst
- unusual tastes in the mouth; metallic, sour, sweet, chemical,
- swollen glands or lumps; where? _____

Cardiovascular

- high blood pressure
- low blood pressure
- blood clots
- phlebitis

- dizziness
- fainting
- chest pain
- cold hands/feet
- difficulty breathing
- palpitations
- tachycardia (fast)
- bradycardia (slow)
- irregular heartbeat
- swelling of hands/feet
- insomnia
- fatigue
- “disquieted spirit,” vexation, agitation or anxiety
- “lassitude of spirit,” apathetic, unmotivated or despondent
- other, please specify_____

Respiratory

- cough
- coughing up mucus (white/clear? yellow/green? thick/foamy? thin/liquidy?)
- coughing up blood
- phlegmy cough (productive/non-productive?)
- dry cough
- asthma
- bronchitis
- pneumonia
- tight chest
- difficulty breathing when lying down
- other, please specify_____

Gastrointestinal

- nausea
- vomiting
- belching
- indigestion/heartburn
- strong/bad breath
- bad taste in the mouth (chemical, metal, sour, rank)
- GERD (reflux)
- excessive gas
- hemorrhoids
- black stools
- bloody stools
- tendency to loose stools
- diarrhea
- constipation
- abdominal pain
- feeling of heaviness or bloating

- thirst with **no** desire to drink fluids
- thirst with a desire for cold fluids

Genitourinary
- pain with urination
- blood in urine (red, pink or orange tinged)
- cloudy urine
- dark urine
- urinary frequency
- urinary urgency
- urinary tract infections (UTIs)
- unable to complete urination
- dribbling
- leaking with cough or sneeze
- wake to urinate more than once/night
- kidney stones
- hernia (abdominal)

Prostate & other male issues (men, please indicate the following issues that relate)
- impotence
- erectile disfunction
- premature ejaculation
- low sperm count (infertility)
- low sperm mobility (infertility)
- penile pain or discomfort
- pain with urination
- stop and start urination
- frequency or urination
- urgency of urination
- other, please specify_____

Gynecology & Pregnancy (women please complete the following, where applicable)
- age at menarchy (1st period) _____yrs.
- LMP _____
- length of menstruation (average) _____ days
- age at menopause (if applicable) _____yrs.
- hysterectomy (date) _____
- peri-menopause (date began) _____
- #pregnancies _____
- #births _____
- #miscarriages _____
- #premature births _____
- PMS
- breast lumps
- irregular periods
- painful periods

- light periods
- heavy periods
- clotting with period
- excessive, painful or itchy discharge
- night sweats
- hot flashes
- lack of libido
- other, please specify_____

Neuropsychological/Psychological

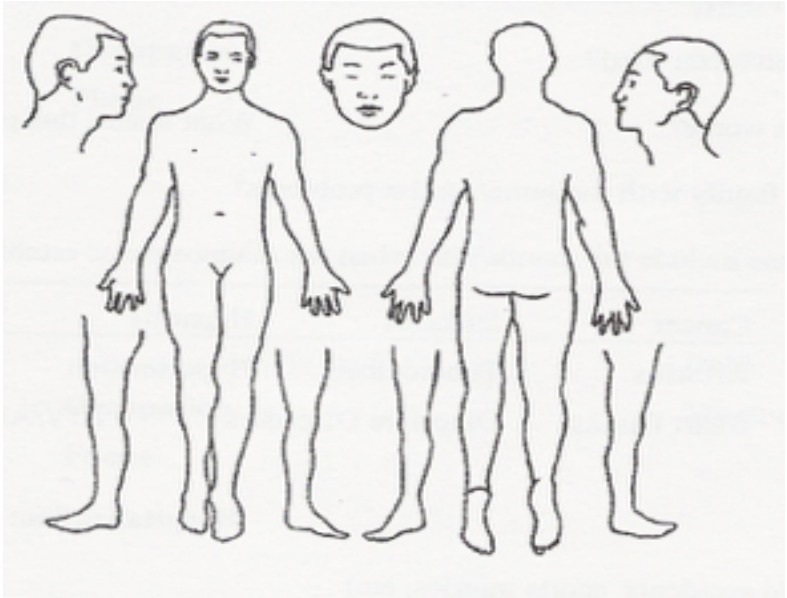
- dizziness
- dizziness upon standing
- vertigo
- seizures
- epilepsy
- concussions
- memory deficiency
- tremors
- numbness/tingling
- localized weakness, please specify location _____
- poor coordination or balance
- Bell's Palsy, facial paralysis
- hemiplasia, unilateral
- paralysis, other
- stroke
- easily/often feeling stressed
- dealing with excessive stress
- easily/often angered or frustrated
- easily/often upset (crying, emotional)
- anxiety
- irritability
- depression
- bipolar
- other, please specify_____

Musculoskeletal [Acu use only: Location, Quality, Severity, Context, Remit/Exacer, Ass., Feeling; sharp/dull/distend/burn; fixed/mov/radiate; b/w w C/H, press/move]

Limited range of motion in (please circle all that apply & indicate Right or Left):
Neck, Shoulder (R/L), Elbow (R/L), Wrist (R/L), Back, Hip (R/L), Knee (R/L), Ankle (R/L)

Pain or Stiffness:
- head pain or stiffness
- neck pain or stiffness
- jaw pain
- arm pain
- leg pain
- knee pain or stiffness
- shoulder pain or stiffness
- swollen joint(s)
- red or hot joints
- heavy feeling limbs
- low back pain or stiffness
- upper back pain or stiffness
- groin pain
- foot/ankle pain
- hand/wrist pain, numbness/tingling or stiffness
- arthritis (rheumatoid? or osteoarthritis?)

Please indicate any areas of **injury**, **pain, soreness or stiffness** on image below:
"**X**" Sharp pain, soreness/stiffness originates
"**O**" Dull pain, soreness/stiffness originates
"**---------->**" For any radiation of pain etc.



RED = injury, pain YELLOW = stiffness GREEN = surgery, numbness, tingling or other

Please share any other pertinent info about you or your health.

~Thank you~
Donna Lynne Strong Brott LAc