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The following is considered privileged information. Your answers are absolutely confidential.

Name:______________________________________Date of Birth:______________Date:___________

Your preferred contact number: _______________________________ *(home/mobile/work)*

Alternate contact number: ____________________________________*(home/mobile/work)*

*Home Address:*____

*Email:*____ *Do you need appointment reminders? YES/NO*

*If yes, how would you like to be contacted: phone/email/text, at this number*____________________________

24 hour cancellation policy: You are responsible for missed appointments with less than 24 hours cancellation notice and will be charged. The whims of Mother Nature are exceptions (weather, illness). Failure to receive an appointment reminder is not an exemption. Please initial that you understand this policy:____

*Occupation:*___________________*Emergency Contact:*____________________*Phone:*_________________

*Have you had acupuncture before?*_____ *Have you been treated by a Chinese herbalist before?*_______

Current Medications: (any prescriptions, vitamins, herbs and other medications that you take regularly)

____
____
____
____

*Allergies:(include drugs, foods, latex, animals,etc)*____

____

*Hospitalizations/Surgeries:(include the year and the diagnosis or operation)*_____________________________

____
____
____

Please circle any conditions your have experienced, past or present: High Cholesterol Heart problems Stroke High blood pressure Seizures Diabetes Hepatitis/jaundice HIV/AIDS Concussion Mononucleosis Eczema Eating Disorder Asthma Thyroid disorder Appendicitis Tuberculosis Gallstones Pneumonia Autoimmune disease Prolonged or frequent use of antibiotics or steroidal drugs (eg Prednisone)

Cancer: ____*Addictions:*_____________________________

*How often do you use the following substances? coffee*_______*black/green tea* __________ *nicotine*________
*alcohol*_____*sugar in any form*________ *soft/energy drinks*______ *non-medical drugs*_______
artificial sweeteners

*What kinds of physical exercise do you do and how often do you do them?*______________________________

____
____

Describe your chief complaint:

When did this develop?
How did this develop?

Does anything make it better or worse? Consider time of day, position, heat or cold, stress, emotions, kinds of medical care, menstrual cycle, adequate rest, lack of sleep, certain foods, eating, not eating, damp or rainy weather, exercise or stretching.

*Better:*____

*Worse:*____

Please take the time to fill out the following. The information that you provide will allow me to formulate a complete health profile for you. Circle the symptoms that you experience currently or have experienced frequently in the last year.

General

- ☐frequent colds
- ☐warmer than other people/hot hands or feet
- ☐cooler than other people/cold hands or feet
- ☐hotflashes
- ☐fevers
- ☐muscle weakness or easy fatigue
- ☐seizures
- ☐lack of coordination
- ☐loss of balance
- ☐tremors
- ☐tics
- ☐sweats easily
- ☐rarely sweats
- ☐always thirsty
- ☐never thirsty
- ☐I can't gain weight.
- ☐I can't loose weight.
- ☐Swelling
  - ☐ in hands
  - ☐ in face
  - ☐ ankles or legs

- ☐tends to overreact
- ☐easily startled
- ☐tends to hold in emotions
- ☐has difficulty relaxing
- ☐mentally restless
- ☐fuzzy headed/unclear thinking
- ☐low motivation
- ☐highly motivated
- ☐obsessive thinking
- ☐poor memory
- ☐anxiety/panic attacks
- ☐depression
- ☐sadness
- ☐worry
- ☐seasonal affective disorder
- ☐irritability
- ☐frequent anger
- ☐easily stressed
- ☐emotionally changeable
- ☐attention deficit disorder
- ☐uncontrolled crying

Chest

- ☐chest pain
- ☐chest tightness
- ☐hard time breathing deeply
- ☐palpitations/heart racing
- ☐cough or wheezing
- ☐recurrent bronchitis/pneumonia

Sleep

- ☐Wakes during the night
  - ☐to urinate: __ times
  - ☐for no reason
  - ☐because of dreams
  - ☐physically restless
  - ☐mentally restless
  - ☐with heart racing/palpitations
  - ☐ in a fright
- ☐feels unrested in the morning
- ☐hard to fall asleep
- ☐snores
- ☐nightmares
- ☐night terrors
- ☐nightsweats

Number of hours of sleep a night: ___

Head and Neck

- ☐history of concussion
- ☐headaches
  - ☐migraines
  - ☐tension
  - ☐sinus headaches
- ☐dizziness/vertigo
- ☐light sensitivity
- ☐poor vision
- ☐spots/floaters in vision
- ☐poor night vision
- ☐eye pain
- ☐eye itching
- ☐face pain
- ☐jaw pain
- ☐tmj
- ☐facial twitches
- ☐sinus congestion
- ☐blows nose in morning
- ☐recurrent sinus infections
- ☐runny nose
- ☐earaches
- ☐loss of hearing
- ☐ringing in ears
- ☐recurrent ear infections
- ☐recurrent sore throats
- ☐hoarseness
- ☐difficulty swallowing
- ☐lump in throat
- ☐phlegm in throat
- ☐hayfever/allergies

Skin/surface

- ☐dry skin
- ☐excessively oily skin
- ☐psoriasis
- ☐eczema
- ☐red, inflamed skin
- ☐slow to heal sores
- ☐acne
- ☐hives
- ☐varicose veins
- ☐abnormal hair loss
- ☐swollen glands
- ☐brittle/soft/peeling nails

Digestion

☐restricted diet: explain_______________________________

____

- ☐poor appetite
- ☐eats at irregular times
- ☐emotional/stress related overeating
- ☐eats sweets often
- ☐indigestion
- ☐often feels bloated
- ☐stomach ache
- ☐nausea
- ☐vomiting
- ☐frequent gas
- ☐burping
- ☐bad taste in mouth
- ☐acid reflux/GERD
- ☐mouth sores
- ☐irritable bowel syndrome (IBS)
- ☐hemorrhoids
- ☐bowel movements
  - ☐how many a day___
  - ☐skips one or more days
  - ☐cramping or pain with stool
  - ☐sticky stool, hard to clean up
  - ☐urgent
  - ☐loose
  - ☐watery
  - ☐contains undigested food
  - ☐foul odor
  - ☐contains mucus
  - ☐contains blood
  - ☐light, tan or white colored
  - ☐black and tarry
  - ☐dry, hard stools
  - ☐pencil thin stools
  - ☐rabbit/pellet stools
  - ☐alternating loose stools and constipation
  - ☐ungratifying/partial defecation
  - ☐need laxatives, coffee, or other assistance to have a bowel movement

Urination

- ☐infrequent urination
- ☐frequent urination
- ☐urgent urination
- ☐incomplete urination
- ☐loss of urine control
- ☐dark urine
- ☐discomfort with urination
- ☐scanty urine
- ☐profuse urine

Musculoskeletal

☐weakness in lower back, hips, knees, ankles or feet

Pain, weakness, or numbness in

- ☐upper back
- ☐middle back
- ☐lower back
- ☐neck
- ☐shoulders
- ☐arms
- ☐elbows
- ☐hips
- ☐knees
- ☐ankles
- ☐feet
- ☐all joints
- ☐legs

Men Only

- ☐genital pain
- ☐groin pain
- ☐impotence
- ☐sexual dysfunction
- ☐discharge from penis
- ☐varicocele/hydrocele
- ☐prostate problems
- ☐low sperm count
- ☐low sperm motility
- ☐poor sperm morphology

Women Only

Age at which menses began________

Date last period began_____________
Date prior period began____________

Normal number of days (not on medication) between the start of one period and the start of the next_________
Number of days of flow_________
Any recent changes in your normal pattern?_______________
Amount of flow______________________
Color of flow ☐pink ☐red ☐dark red ☐purple
☐brown ☐black
Any clots?________ Size/color of clots__________________
Any cramps?____When, where and how intense?__________

Any premenstrual symptoms?__________________________
____
When do they start?___________________________

Do you bleed or spot between periods? If so, when?________
____

Do you have any symptoms, such as breast tenderness, bloating, headaches, or abdominal pain, around midcycle or ovulation?____
____
Have you taken medication to help you ovulate?___________

Vaginal itching?________ Vaginal sores?_______________
Vaginal dryness?_____
Describe any vaginal discharge that you have through the month:____
____

Do you get yeast infections regularly?_________
Do you have a history of sexually transmitted disease?______
If so, please describe:_________________________
Do you douche ?____Do you use vaginal lubricants?_______

Date of last PAP smear_____________
Have you ever had an abnormal PAP smear?______________
Have you ever had a cervical biopsy, cauterization or conization, or other procedure on your cervix?_____________

How many pregnancies have you had?_________________
Have you been diagnosed with uterine fibroids or polyps?____
Have you been diagnosed with endometriosis?_____________
Have you been diagnosed with pelvic adhesions?___________
Have you been diagnosed with any pelvic abnormalities?____
Have you had any tubal operations?_____________________
Current birth control method:__________________________
Have you ever used an IUD?___________________________
Have you ever been on the birth control pill?______________
Have you ever used Depoprovera?______________________
Are you trying to get pregnant?_________________________
Do you have excess facial or chest hair?__________________
Do you have excessively oily skin?______________________
Do you have breast tenderness?_______ Lumps?___________
Have you noticed discharge from your nipples?____________