

|                                 |         |                                                                                                                                                                                                                                                                                 |             |                                                                                                              |       |               |
|---------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|--------------------------------------------------------------------------------------------------------------|-------|---------------|
| Name:                           |         |                                                                                                                                                                                                                                                                                 | Gender:     |                                                                                                              | Age:  |               |
| Address:                        |         |                                                                                                                                                                                                                                                                                 | City:       |                                                                                                              | Prov: | Postal Code:  |
| Home Phone #:                   |         | Other Phone #: Work Cell Other                                                                                                                                                                                                                                                  |             | Email: <input type="checkbox"/> Yes, please include me in emails regarding sales and events.                 |       |               |
| Date of Birth:                  |         | Emergency contact:                                                                                                                                                                                                                                                              |             | Contact #:                                                                                                   |       | Relationship: |
| Height:                         | Weight: | Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other : _____ |             |                                                                                                              |       |               |
| Employer:                       |         |                                                                                                                                                                                                                                                                                 | Occupation: |                                                                                                              |       |               |
| Physician:                      |         |                                                                                                                                                                                                                                                                                 |             | Physician's Phone #:                                                                                         |       |               |
| How did you hear of our clinic? |         |                                                                                                                                                                                                                                                                                 |             | Have you had Acupuncture before?<br><input type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___ |       |               |

**MAIN CONCERNS**

Please write in up to 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

↓

**1** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

**2** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

**3** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

**HEALTH HISTORY**

Circle the **↑** if you have / had the condition and note the year it started.  
Circle the **↑↑↑** if there is a family history of the condition.

|                        | YOU     | Year | FAMILY    |                           | YOU     | Year | FAMILY    |
|------------------------|---------|------|-----------|---------------------------|---------|------|-----------|
| Cancer <i>type(s)?</i> | ↑ _____ |      | ↑↑↑ _____ | Osteoporosis              | ↑ _____ |      | ↑↑↑ _____ |
| Diabetes               | ↑ _____ |      | ↑↑↑ _____ | Herpes                    | ↑ _____ |      | ↑↑↑ _____ |
| Hepatitis              | ↑ _____ |      | ↑↑↑ _____ | AIDS / HIV                | ↑ _____ |      | ↑↑↑ _____ |
| High Blood Pressure    | ↑ _____ |      | ↑↑↑ _____ | Other STD                 | ↑ _____ |      | ↑↑↑ _____ |
| Heart Disease          | ↑ _____ |      | ↑↑↑ _____ | Rheumatic Fever           | ↑ _____ |      | ↑↑↑ _____ |
| Stroke                 | ↑ _____ |      | ↑↑↑ _____ | Alcoholism                | ↑ _____ |      | ↑↑↑ _____ |
| Seizure Disorder       | ↑ _____ |      | ↑↑↑ _____ | Allergies <i>type(s)?</i> | ↑ _____ |      | ↑↑↑ _____ |
| Thyroid Disease        | ↑ _____ |      | ↑↑↑ _____ | Mental Illness            | ↑ _____ |      | ↑↑↑ _____ |
| Asthma                 | ↑ _____ |      | ↑↑↑ _____ | Kidney Disease            | ↑ _____ |      | ↑↑↑ _____ |
| Pacemaker              | ↑ _____ |      | ↑↑↑ _____ | Anemia                    | ↑ _____ |      | ↑↑↑ _____ |

**HABITS**

Amount / Week If Quit, Year?

Coffee / Tea \_\_\_\_\_

Soda \_\_\_\_\_

Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

Drugs \_\_\_\_\_

**EXERCISE**

Do you exercise regularly?  Yes  No

If so, what and how often:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DIET** Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)  
Describe w/ dates:

**MEDICATIONS**

Please note what medications, herbs or supplements that you take regularly

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INJURIES & SURGURIES**

Please note what happened to what body area and when it occurred (incl. dental)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

#### COLD

#### HOT

- |                                              |                                                       |                                         |                                                 |
|----------------------------------------------|-------------------------------------------------------|-----------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Thirst for cold / hot drinks | <input type="checkbox"/> Night sweats   | <input type="checkbox"/> Hot hands, feet, chest |
| <input type="checkbox"/> Chills              | <input type="checkbox"/> Thirst, no desire to drink   | <input type="checkbox"/> Unusual sweats | <input type="checkbox"/> Hot flashes            |
| <input type="checkbox"/> Cold "in the bones" | <input type="checkbox"/> Absence of thirst            | When _____ am / pm                      | <input type="checkbox"/> Hot in afternoon       |
| <input type="checkbox"/> Areas of numbness   | <input type="checkbox"/> Excessive thirst             | Where on body _____                     | <input type="checkbox"/> Hot at night           |

### MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

#### DRY

#### OILY

- |                                            |                                                |                                                 |                                                                     |
|--------------------------------------------|------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Dry skin          | <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Edema / Swelling _____ | <input type="checkbox"/> Oily skin                                  |
| <input type="checkbox"/> Dry hair          | <input type="checkbox"/> Dry lips              | <input type="checkbox"/> Rashes _____           | <input type="checkbox"/> Oily hair                                  |
| <input type="checkbox"/> Dry eyes          | <input type="checkbox"/> Dry throat            | <input type="checkbox"/> Itching _____          | <input type="checkbox"/> Pimples                                    |
| <input type="checkbox"/> Dry brittle nails | <input type="checkbox"/> Dry nose / Nosebleeds | <input type="checkbox"/> Dandruff               | Where on your body?:<br><input type="checkbox"/> Weight gain / loss |

### DIGESTION

#### DIARRHEA

#### CONSTIPATION

- |                                                                          |                                        |                                            |                                               |
|--------------------------------------------------------------------------|----------------------------------------|--------------------------------------------|-----------------------------------------------|
| BM: How often? _____ x / every _____ days                                | <input type="checkbox"/> Gas           | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Dry Stools           |
| Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Bloating      | <input type="checkbox"/> Bad breath        | <input type="checkbox"/> Difficult to pass    |
| <input type="checkbox"/> Alternating diarrhea & constipation (IBS)       | <input type="checkbox"/> Belching      | <input type="checkbox"/> Heartburn         | <input type="checkbox"/> Tired after BM       |
| <input type="checkbox"/> Indigestion                                     | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive hunger  | <input type="checkbox"/> Foul smelling stools |

### ENERGY

#### LOW

#### HIGH

- |                                                   |                                                              |                                                    |                                                   |
|---------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Sudden energy drop       | <input type="checkbox"/> Dependence on caffeine / stimulants | <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Hard to concentrate      |
| Time of day: _____ am / pm                        | <input type="checkbox"/> Wired / ungrounded feeling          | <input type="checkbox"/> Heart Palpitations        | <input type="checkbox"/> Poor memory              |
| <input type="checkbox"/> Energy drop after eating | <input type="checkbox"/> Body / Limbs feel heavy             | <input type="checkbox"/> Blood pressure High / Low | <input type="checkbox"/> Dizziness / lightheaded  |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Body / Limbs feel weak              | <input type="checkbox"/> Bleed / Bruise easy       | <input type="checkbox"/> Headaches _____ x / week |

### SLEEP

- # hours per night \_\_\_\_\_
- Difficulty falling asleep
  - Wake \_\_\_\_\_ x / night @ \_\_\_\_\_ am / pm
  - Wake to urinate How often? \_\_\_\_\_
  - Disturbing dreams
  - Restless sleep
  - Not rested upon waking

### EMOTIONS

- What emotion(s) dominate your experience?
- |                                             |                                      |
|---------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger              | <input type="checkbox"/> Grief       |
| <input type="checkbox"/> Irritability       | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Joy         |
| <input type="checkbox"/> Worry              | <input type="checkbox"/> Fear        |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Timid / shy |
| <input type="checkbox"/> Sadness            | <input type="checkbox"/> Indecision  |

### EYES, EARS NOSE THROAT

- |                                                 |                                          |
|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Night blindness        | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes               | <input type="checkbox"/> Excess earwax   |
| <input type="checkbox"/> Itchy eyes             | <input type="checkbox"/> Sore throat     |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Sinus congestion       | <input type="checkbox"/> Mouth sores     |
| <input type="checkbox"/> Phlegm (color _____)   | <input type="checkbox"/> Cough           |

### MENSES (IF APPLICABLE)

### MENOPAUSE

Age at last menses : \_\_\_\_\_  Hot flashes \_\_\_\_\_ x / day  Vaginal dryness  
 Year changes began: \_\_\_\_\_  Night sweats \_\_\_\_\_ x / week  Loss of sex drive

- |                                       |                                                                             |                                            |                                                        |
|---------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------|
| Age at first menses: _____            | <input type="checkbox"/> Heavy periods                                      | <input type="checkbox"/> Cramps            | <input type="checkbox"/> Mood changes                  |
| Length of full cycle: _____ days      | <input type="checkbox"/> Light periods                                      | <input type="checkbox"/> Before bleeding   | <input type="checkbox"/> Fatigue w/ menses             |
| Length of menses: _____ days          | <input type="checkbox"/> Painful periods                                    | <input type="checkbox"/> First day         | <input type="checkbox"/> Digestive changes w/ menses   |
| Last menses start date: _____ / _____ | <input type="checkbox"/> Irregular periods                                  | <input type="checkbox"/> During period     | <input type="checkbox"/> Midcycle spotting             |
| # of pregnancies: _____               | <input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS) | <input type="checkbox"/> Clots             | <input type="checkbox"/> Yeast infections              |
| # of births: _____ premature _____    |                                                                             | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Birth control pill (hormonal) |
| # of abortions / miscarriages: _____  |                                                                             |                                            |                                                        |

### URINARY (IF APPLICABLE)

- |                                                                             |                                             |
|-----------------------------------------------------------------------------|---------------------------------------------|
| Fluid in = fluid out? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Urgency to urinate |
| <input type="checkbox"/> Decrease in flow                                   | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Dribbling                                          | <input type="checkbox"/> Pain on urination  |
| <input type="checkbox"/> Difficulty starting / stopping                     | <input type="checkbox"/> Burning sensation  |
| <input type="checkbox"/> Incontinence                                       | <input type="checkbox"/> Cloudy urine       |
| <input type="checkbox"/> Kidney stones                                      | <input type="checkbox"/> Blood in urine     |

### REPRODUCTIVE (IF APPLICABLE)

- |                                                                                |                                           |
|--------------------------------------------------------------------------------|-------------------------------------------|
| Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Prostate disease |
| <input type="checkbox"/> Change of sexual drive: ↑ ↓                           | <input type="checkbox"/> Genital Pain     |
| <input type="checkbox"/> Erectile dysfunction                                  | <input type="checkbox"/> Jock Itch        |
| <input type="checkbox"/> Premature ejaculation                                 | <input type="checkbox"/> Vasectomy        |
| <input type="checkbox"/> Sores on genitals                                     | <input type="checkbox"/> Hernia           |
| <input type="checkbox"/> Discharge                                             | <input type="checkbox"/> Hemorrhoids      |