

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

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: _____

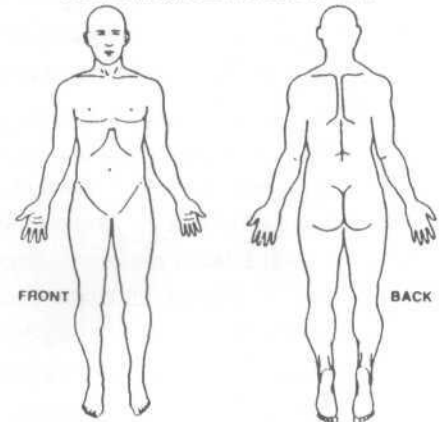
EYES: Eye pain Dry eyes Blurred vision Darkness under eyes Other: _____

EARS: Poor hearing Earaches Ear discharge/infections Ringing/buzzing in ears

Other: _____

NOSE: Frequent nose bleeds Sinus trouble Frequent colds Other: _____

PLEASE MARK YOUR AREAS OF PAIN



THROAT: Sore throat Hoarseness Difficulty swallowing Jaw problems Teeth/gum problems Swollen tongue

Other: _____

CHEST: Hard to breathe Wheezing Shortness of breath Mucus rattles when breathing Trouble breathing at night
 Pain/pressure in chest Palpitations Persistent cough Coughing blood Coughing phlegm

Sputum color _____ Consistency _____

Other: _____

BLOOD PRESSURE: High Low Do not know

BOWELS: Diarrhea Constipation Bloody stools Black stools Mucus in stools Hemorrhoids

Lower bowel gas Stools have foul odor Colon problems Number of bowel movements a day _____

Other: _____

URINE: Color _____ Amount _____ Frequent urination Daytime At night

Strong smelling urine Hard to urinate Pain or burning on urinating Blood in urine

Frequent infections Water retention Other: _____

MUSCULOSKELETAL: Pain in: Neck Shoulder Between shoulders Arms/hands Hip Knee

Fingers Big toe Upper back Mid back Lower back Bones sore/painful Loss of grip

Swollen knees/elbows Leg cramps at night Weakness in legs Weak ankles Stiff all over

Tingling in feet Muscle spasm/cramps Loss of feeling in hands/feet Painful joints Bursitis

Other: _____

NEUROLOGICAL: Nervousness Depressed Easily angered Easily irritated Frequent crying

Worry/Anxiety Mood swings Memory confusion Poor concentration Suicidal Tremors

Numbness/tingling in limbs Poor coordination Muscle weakness Feel weak and shaky Seizures

Neuralgia (nerve pain) Shingles Other: _____

FEMALES: Pregnant? yes No Last monthly period _____ Last PAP test _____

Form of birth control: None Pill Other: _____

Age started menstrual cycle _____ Age stopped _____ Menstrual pain Low backache

Irregular Clotting Heavy bleeding Light scanty bleeding Color _____

Water retention Mood changes Miss periods Low or no sex drive Painful breasts Hot flashes

Food cravings Other: _____

Discharges: Yellow Thick White Odor Itching Liquid Other: _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____

No. Cesareans _____ Operations: Cervix Uterus Ovaries Other: _____

MALES: Low sexual drive Lack of sexual drive Impotence Ejaculation causes pain Discharges

Pain or burning while urinating Premature ejaculation Prostate trouble Other: _____

APPETITE: Excessive appetite Poor appetite Appetite keeps changing Feel tired or weak if a meal is missed

Excessive thirst Never thirsty Other: _____

Specific food cravings? Yes No If yes, what? _____

Other: _____

DIGESTION: Stomach gas Lower bowel gas Heartburn Burning/belching Stomach pain

Stomach cramps Nausea Vomiting Bad breath Sores in mouth Weight gain Weight loss

Bitter/sour taste in mouth Abdominal bloating How long after eating? _____

Food allergies? yes No If yes, to what? _____

NUTRITION: List some of your favorite foods _____

Do you: Skip breakfast Eat a snack Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? Yes No How often? _____

Do you plan your meals according to the "Four basic food groups"? Yes No

How many glasses of water do you drink a day? _____ Filtered Bottled

Do you use: Alcohol? Yes No Amount per week _____ Type _____
 Tobacco? Yes No Packs per day _____ How many years _____

DO YOU:

Eat raw fruits or vegetables at least twice a day? Yes No
 Eat green or yellow vegetables at least twice a day? Yes No
 Eat frequently between meals? Yes No
 Chew your food thoroughly before swallowing it? Yes No
 Drink juice, milk or other drinks instead of water when thirsty? Yes No
 Always add salt at the table? Yes No

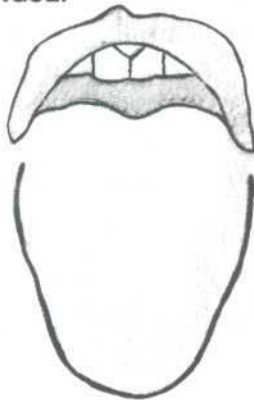
Eat meat or dairy products 2 or more times a day? Yes No
 Eat the same foods almost every day? Yes No
 Eat when you are not hungry? Yes No
 Eat until you feel full? Yes No
 Occasionally go on a "crash" diet? Yes No

Patient's Signature _____

DO NOT WRITE BELOW THIS LINE

EXAMINATION

TONGUE:



Color _____

 Coat _____

 Body _____

PULSE

RIGHT LEFT

GENERAL CHARACTER

TEMPERATURE: _____
 BLOOD PRESSURE: _____

APPEARANCE: Excellent Good Fair Well-nourished Undernourished Debilitated Thin
 Husky Overweight _____

MOVEMENT: Guarded Slow Impaired Needs assistance Deformity _____

SKIN COLOR: _____ **FACIAL COLOR:** _____ **EYES:** _____

AREA CLIMATE: Body odors _____ Smell _____

ABDOMEN (by palpation): Organ swelling Masses Hernia Pain _____

ABDOMINAL REFLEX(es): _____

ASSESSMENT/EVALUATION/FINDINGS: (Internal, emotional, dietary, channel disorders, trauma, constitution, inactivity, overworked, etc.)

EIGHT PRINCIPLES: (Yin/Yang, Internal/External, Hot/Cold, Deficient/Excess) _____