Comprehensive Acupuncture Examination

Name_____Date_____Time_____

Birth Date_____ Height _____ Weight_____

Main Health Issues_____

_____

Other Complaints_____

Date of onset _____Have you had this in the past? ____ If so, when_____

What makes it better? _____

What makes it worse? _____

Is the condition ___ Getting worse ___ Constant ___ Comes and goes Please mark areas of pain

Medications/Drugs/Herbs you are currently taking_____

_____

List surgeries and dates_____

Medical History: (Do you have or have you ever had) Circle- 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_____

History Family (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 Excess Sweating Rarely sweats _____ **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 Hives Other _____ **Scars** (List ALL scars from accidents or surgeries _____

_____

Sleep problems Trouble falling asleep Trouble staying asleep Restful Excess dreaming Hours of sleep a night_____

Head Headaches (what area)_____ Dizziness Memory loss Loss of Balance

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_____

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 Mucus in stools Hemorrhoids Lower bowel gas Stools have foul odor

Colon problems Number of bowel movements daily_____ Color of stool_____

Urine Color_____ Amount_____ Frequent urination Day Night

Strong smelling urine Hard to urinate Pain or burning on urinating Blood in urine Frequent infections Water retention

Musculoskeletal Pain in: Neck Shoulder Between Shoulders Arms/hands Hip Knee Fingers Toes Upper back

Mid back Lower back Bone pain Loss of grip Swollen knees/elbows Leg cramps at night Weakness in legs

Weak ankles Stiffness Tingling: Hands/Feet Muscle spasms/cramps Numbness: Hands/Feet Joint pain Bursitis

Neurological Nervousness Depressed Easily angered/irritated Frequent crying Worry/Anxiety Mood swings

Memory/confusion Poor concentration Suicidal Tremors Neuralgia (nerve pain) Shingles Other_____

Females Pregnant yes/no Last monthly period_____ Last PAP test_____

Age started menstrual cycle_____ Age stopped_____ Menstrual pain Low back ache

Irregular Clotting Heavy bleeding Light/scanty bleeding Color _____ Water retention

Mood changes Missed periods Low or no sex drive Painful breasts Hot flashes Food cravings

Discharges color_____ Thick/watery Odor Itching Other_____

No pregnancies_____ No. deliveries_____ No. miscarriages_____ No. abortions_____

No. cesareans_____ Operations: Cervix Uterus Ovaries Other_____

Male Low sexual drive Lack of sexual drive Impotence Premature ejaculation Painful ejaculation Discharges

Pain/burning while urinating Prostate trouble Other_____

Appetite Excessive sppetite Poor appetite Changing appetite Feel tired/weak if a meal is missed Tired after a meal

Excessive thirst Lack of thirst Other_____

Food cravings Yes/ no If yes, what?_____

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? If yes, what?_____

Nutrition List some of your favorite foods_____

Do you Skip breakfast Eat a snack Eat a heavy breakfast How many meals do you eat a day?_____

When is your biggest meal?_____ Do you eat when you are worried?_____ What?_____

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