ACUPUNCTURE PATIENT HISTORY FORM

Patient Name _____ Date_____

Date of Birth _____

A. A few words to my new patients:

I know this is a long questionnaire, and I too dislike filling out long forms. However, in order for me to provide you with a successful acupuncture experience with lasting results, I need you to take this time to complete this history information form as completely and accurately as you can. Thank you.

B. CHIEF COMPLAINT: _____

C. Additional (secondary) Complaints (Briefly list other physical, emotional, mental, etc. issues):

_____
_____
_____
_____

D. Past Medical History

1. Please list any drugs, medications (prescribed and OTC), nutritional supplements you are now taking or have taken in the last 3 months.

Name Dosage Times/Day Reason

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____
g. _____
h. _____
i. _____
j. _____

2. Accidents and Injuries

Approximate date Type of injury How did this happen? Full recovery?

a. _____
b. _____
c. _____
d. _____
e. _____

3. Hospitalizations

	Approximate date	Reason
a.		
b.		
c.		
d.		

4. Surgeries:

	Approximate date	Type of surgery	Reason for surgery	Complications
a.				
b.				
c.				
d.				

5. Serious illnesses (not listed above):

	Type of illness	Date of onset	Full recovery Yes/No (Explain if No)
a.			
b.			
c.			
d.			

6. Allergies:

Please list all allergies (medications, foods, plants, animals, etc. and type of reaction

	Allergy	Type of reactions.
a.		
b.		
c.		
d.		
e.		
f.		

7. Pregnancies:

	Year of birth	Delivery normal/abnormal (Describe if abnormal)
a.		
b.		
c.		
d.		
e.		

8. If you have had any of the following ailments/diseases please check and list your age when.

_____ pneumonia	_____ high blood pressure	_____ kidney infection
_____ tuberculosis	_____ low blood pressure	_____ parasites
_____ hepatitis	_____ heart disease	_____ rheumatic fever
_____ asthma	_____ heart attack	_____ German measles
_____ diabetes	_____ cancer	_____ regular measles
_____ hypoglycemia	_____ blood transfusion	_____ mumps
_____ epilepsy	_____ migraine headache	_____ chicken pox
_____ eczema	_____ ulcer, stomach	_____ polio
_____ skin boils	_____ anemia	_____ whooping cough
_____ kidney stones	_____ arthritis	_____ diphtheria
_____ drug reaction	_____ overweight	_____ colitis
_____ psoriasis	_____ mental illness/breakdown	_____ STD
_____ hives	_____ jaundice	_____ varicose veins
_____ skin ulcer	_____ stroke	_____ hyperglycemia
_____ pancreatitis	_____ diverticulitis	_____ bowel obstruction
_____ urinary tract infection (UTI)		_____ other

E. Social History

1. Smoking ____ current ____ past & when ____ never ____ packs/day

2. Alcohol ____ regularly ____ occasionally ____ rarely ____ never
   Type____ wine ____ beer ____ liquor ____ servings/day

3. Recreational drugs: kind _____ frequency _____ duration _____
   kind _____ frequency _____ duration _____

4. Foreign travel: ____ never ____ once a year ____ more than once a year

5. Dietary habits:
   Eating meals at restaurants ____ 0-1/week ____ 2-3/week ____ 4 or more/week
   Food preferences (check all that are appropriate for you):
   ____ hot spicy ____ red meat ____ vegetables ____ food blend
   ____ fruits ____ sweets ____ chocolate ____ smoothies
   ____ dairy products ____ frequent snacks ____ other_____

6. Daily beverages ____ coffee (cups/day) ____ am ____ pm ____ evening
   ____ tea (cups/day) ____ am ____ pm ____ evening
   ____ caffeine ____ decaffeinated
   ____ soda (per day) ____ regular ____diet
   ____ caffeine ____ decaffeinated
   ____ water (cups/day) ____ filtered/bottled ____ regular/tap

F. Family History:

	Sex	Living/age	Health Problems	Deceased/age	Cause
Father					
Mother					
Siblings					
Children					

G. Personal History:

Place of birth _____ Highest education_____

____Married ____Single ____Other

____Live alone ____Live with a friend ____Live with spouse ____Live with family

Do you have support at home? ____ Yes ____ No

H. System Review:

1. General:

My health is ____ Excellent ____ Good ____ Fair ____ Poor

My energy level is ____ Normal ____ Decreased ____ Increased ____ Varies

I experience: ____ Fatigue ____ Fever ____ Sweats ____ Chills ____ Poor Appetite

My weight is ____ 1 year ago ____ 5 years ago ____ My best weight is ____

2. Skin: ____ Rashes ____ Bleeding ____Other_____

3. Eyes: Any problems? _____

4. Nose, Throat, Sinuses

____ Blowing nose ____ Sneezing ____ Sinuses ____ Post nasal drip

____ Sinus infection ____ Loss of smell ____ Frequent colds ____ Sore throats

____ Hoarseness ____ Throat clearing ____ Tickle in throat ____Other_____

5. Breasts:
   Date of last physical exam _____ Date of last mammogram _____
   Mammogram results_____
   Breast biopsy ____ Date _____ Results_____
   Breast cancer____ Date _____
   Lumpectomy ____ Biopsy ____ Mastectomy ____
   Chemotherapy ____ Radiation therapy ____
   Other _____

6. Heart:
   Have you been told you have heart disease? ____
   Rheumatic fever ____ Angina pectorus ____ Palpitations ____ Ankle swelling ____
   Chest pain or pressure ____ Describe _____
   Heart attack ____ Heart failure ____
   High blood pressure ____ Date of onset _____ Highest pressure _____
   High cholesterol ____ How high _____
   How many times a night do you wake to urinate? ____
   Does shortness of breath awaken you from sleep? ____
   Can you sleep flat in bed? ____ Need to raise on pillows? ____ How many pillows? ____
   Other _____

7. Stomach and Digestion:
   Heartburn ____ Frequent upset stomach ____ Ulcer ____ Gas/belching ____
   Acid taste in mouth ____ Difficulty swallowing ____ Food sticking ____ Regurgitation ____
   Hiatal hernia ____ Nausea ____ Vomiting ____ Diarrhea ____ Constipation ____
   Abdominal pain ____ Change in shape or frequency of stools____ Blood in stools ____
   Other _____

8. Genital / Urinary System:
   Difficulty urinating ____ Painful urination ____ Kidney or bladder stone ____
   Blood in urine ____ Urinary incontinence ____ Urinary or kidney infection ____
   For men: Slow or difficult urination ____ Prostate problem ____
   Other _____

9. Hematological System:
   Do you have anemia? ____ What type? _____ Iron deficiency? ____ Other _____
   Blood clots: Venous thrombosis ____ Pulmonary embolus ____
   If either explain_____
   Have you had blood transfusions? ____ Date(s) _____
   Other _____

10. Endocrine System:
Diabetes ____ Type 1 ____ Type 2 ____ Hypoglycemia ____
Have you been given a diet for weight loss? _____ for weight gain? ____ for diabetes? ____
For renal deficiency/failure ____ Other_____
Thyroid disease? _____ If yes: Hyperthyroidism_____ Hypothyroidism ____
Changes in hair texture/thickness ____ Skin changes____ Appetite changes ____
Heat intolerance ____ Cold intolerance ____
Other _____

11. Musculo-Skeletal System:
Joint status: Swelling ____ Pain ____ Redness ____ Warmth ____ Tenderness ___
Have you been told you have arthritis? ____ If yes, explain _____
Do your fingers turn white ____ or blue ____ in the cold?
History of Fractures ____ Dislocations ____ Orthopedic Surgery If yes to any, explain
_____
Other _____

12. Psychiatric:
Are you Nervous ____ Worried ____ Depressed ____ Anxious ____ Sad ____
If yes to any, explain _____
Other _____

13. Miscellaneous:
Is there anything else you would like me to know about your health or what you want to get out of this visit?_____

Sexual Function:
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Male ____ Inability to get or maintain erection ____Burning ejaculation
____ Easy arousal ____ Wet dreams
____ Premature ejaculation ____ Lack of libido
____ inability to ejaculate ____ Weak orgasm

Female ____ Lack of libido ____ Discomfort with cloitus
____ Weak or absent orgasm ____ Frequent cystitis from cloitus

Water Intake:
Thirsty often and drinks a lot of water/fluid ____ Thirsty but stops after a couple sips ____
A strong preference to drink hot ___ or cold ____ beverages.

History of Stress:
Describe below the event or cluster of events that have been the most traumatic for you and select the emotion that predominated during these stressful situations. For instance, you have witnessed a close friend killed by a drunk driver. The overwhelming emotion may be sorrow or anger.
Date _____ Event _____ Emotion _____

Sleep History:
Do you have any of the following sleeping problems?

____ Difficulty falling asleep
____ Restless sleep
____ Frequent and vivid dreams
____ Snoring
____ Waking in the middle of the night
____ Cannot fall back to sleep after waking up
____ Nightmares
____ Talking in your sleep

Gynecologic History:
Average number of days in menstrual cycle ____ Has this changed from the past? _____
Length of mensus _____ Has this changed from the past? _____
Menstrual flow: bright red ____ or dark red ____ Amount: normal ___ light ___ heavy___ Clots?__
Cramps? None ____ Before period starts _____ As period starts _____ Throughout the cycle _____
Do you have mood changes with mensus? ___ If yes, describe _____

On birth control? ____ Pill ____ Other _____ For how long? _____
Menopause ____ Age of onset _____
Vaginal discharge?____ If yes, color – clear __ white __ yellow __ brownish __ bloody with odor __

Do you have abnormal sweating?

____Too much
____ Wake up sweating
____ Sweating of head & neck only
____ Sweating of palms only
____ Too little
____ Spontaneous sweating
____ Sweating of legs only
____ Sweat with strong odor

Do you have any of the following?

____ Feel cold when others do not
____ Noticeable warmth in palms
____ Surge of heat sensation rushing to fever
____ Feel hot when other do not
____ Feverish or flu like symptoms that come & go
____ Prefer staying indoors because wind bothers

How often do you have bowel movements?
____ Once a day ____ Every other day
____ Every 3rd day ____ More than once a day. How often? _____
Other_____

Your stool appearance is (check one or more of the following):
____ Formed ____ Pasty ___ Soft & flaky
____ Watery ____ Hard & pellet-like

____ Presence of mucus ____ Presence of blood

Color of stool:
____ Black ____ Dark color ____ Brown ____ Light color

Do you have urinary symptoms as follows:
____ Urination frequency
____ Getting up at night to urinate

Volume of urine is usually ____small ___ normal ___ large

Unusual urinary symptoms such as ____ burning ____ pain ___ dribbling

Color of urine is ____ dark ____ light yellow ____ colorless (clear)

:

REVIEW OF SYSTEMS (TCM)

Do you have any of the following symptoms at presently, or have recently? Check all symptoms that apply to you.

____ **P**ain	____ **N**umbness	____ **I**tching
____ **R**edness	____ **S**welling	____ **B**urning sensation
____ **C**oldness	____ **O**ther	

If you checked any of the above symptoms, specify body location and grade the severity of the symptom from **0** to **10**, with **0** being no discomfort and **10** being extreme discomfort.

Record the first letter of the symptom and severity # of the symptom adjacent to the diagram with an arrow pointing to the location of the symptom on the body drawing.