Acupuncture Patient Information

First Name _____ Last Name _____ Date _____

Gender (Please circle): M F Date of Birth _____ Age _____

Marital Status (Please circle): Single Married Partnered Separated Divorced

Place of Employment _____ Occupation _____

Who referred you to us? _____

Chief Complaint: _____

How long? _____ How often: _____

What caused this (accident, lifestyle, drug, etc.)? _____

Describe the worst it can be: _____

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _____

_____

Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____

How does this affect your life? _____

Affect your family? _____ Affect your sleep? _____

Affect your work? _____ Affect your hobbies? _____

What is your goal/plan if the problem continues 5/10/20 years? _____

Complaint #2: _____

How long? _____ How often: _____

What caused this (accident, lifestyle, drug, etc.)? _____

Describe the worst it can be: _____

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?

_____

Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____

How does this affect your life? _____

Affect your family? _____ Affect your sleep? _____

Affect your work? _____ Affect your hobbies? _____

What is your goal/plan if the problem continues 5/10/20 years? _____

Complaint #3: _____

How long? _____ How often: _____

What caused this (accident, lifestyle, drug, etc.)? _____

Describe the worst it can be: _____

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?

_____

Get temporary relief? _____ Fixes problem? _____ Causes side effects? _____

How does this affect your life? _____

Affect your family? _____ Affect your sleep? _____

Affect your work? _____ Affect your hobbies? _____

What is your goal/plan if the problem continues 5/10/20 years? _____

Other Complaints: _____

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better_____
Have you had acupuncture before? _____
If yes, where/who _____
Any concerns or fears about the needles? _____
If yes, what? _____
What are your goals of your acupuncture visits?

1. _____
2. _____
3. _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SYMPTOMS – **NOTE**: For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.**

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

BODY TEMPERATURE

Please check all the apply:

_____ Cold entire body
_____ Cold extremities
_____ Hot all day
_____ Hot only in afternoon
_____ Hot only at night
_____ Normal

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

***ENERGY LEVEL** – *Please circle:*

Low 1 2 3 4 5 6 7 8 9 10 High

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

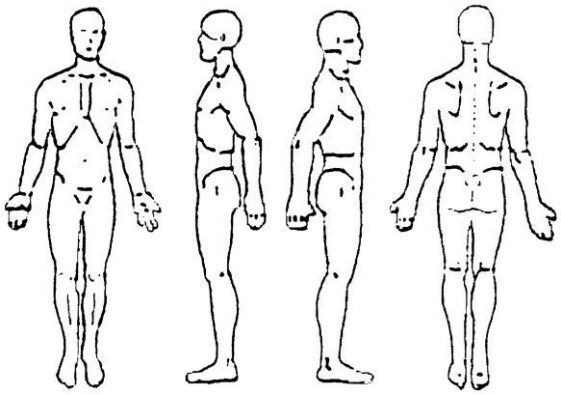
_____

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

☐ Sharp ☐ Burning ☐ Aching
☐ Fixed ☐ Other:_____

Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No

Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period end? _____

Number of days for monthly cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:

☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills

☐ Spermicides ☐ Barriers

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*

- ☐ Severe ☐ Moderate
- ☐ Mild ☐ Before Period
- ☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*

- ☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility

☐ Pelvic Inflam. Disease ☐ Ovarian Cysts

☐ Endometriosis ☐ Hot Flashes

☐ M stitis ☐ Breast Cysts

☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*

- ☐ Fluid Retention ☐ Cravings
- ☐ Fluctuating Emotions ☐ Irritability
- ☐ Tenderness in Breasts ☐ Depression
- ☐ Fatigue

Men Only

☐ Impotence ☐ Weak Erection

☐ Discharge from Penis ☐ Prostate Problems

☐ Testicular Pain or Lump ☐ Infertility

☐ Premature Ejaculation ☐ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet & Lifestyle

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

Please tell us about your exercise (regular, minimal, etc.):

_____

Please list what you ate yesterday:

Breakfast_____

Lunch_____

Dinner_____

Snacks _____

ACID-ALKALINE QUESTIONNAIRE

SECTION A – HISTORY

Circle the number score for each **yes** answer.

1. Have you taken tetracyclines (Sumycin, Panmycin Minocin, Vibramycin, etc.) or other antibiotics for one month or longer? **35**
2. Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory, or other infections for two months or longer, or in shorter courses, four or more times in a one-year period? **35**
3. Have you ever taken a "broad spectrum" antibiotic? **6**
4. Have you ever been bothered by persistent prostatitis, vaginitis, or other reproductive organ problems? **25**
5. Have you been pregnant two or more times? **5**
   One time? **3**
6. Have you taken birth control pills for more than two years? **15**
   For six months to two years? **8**
7. Have you taken Prednisone, Decadron, or other cortisone-type drugs for more than two weeks? **15**
   For two weeks or less? **6**
8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke moderate to severe symptoms? **20**
   Mild symptoms? **5**
9. Are symptoms worse on damp, muggy days, or in moldy places? **20**
10. Have you had severe or persistent athlete's foot, ring worm, jock itch, or chronic fungus infections of the skin or nails? **20**
    Mild to moderate? **10**
11. Do you crave sugar? **10**
12. Do you crave breads? **10**
13. Do you crave alcoholic beverages? **10**
14. Does tobacco smoke *really* bother you? **10**

SECTION A TOTAL _____

SECTION B – MAJOR SYMPTOMS

Enter the appropriate score for each symptom below. If a symptom is *occasional* or *mild*, score **3** points. If a symptom is *frequent* or *moderately severe*, score **6** points. If a symptom is *severe* or *disabling*, score **9** points.

1. Fatigue or lethargy _____
2. Feeling of being "drained" _____
3. Poor memory _____
4. Feeling "spacey" or "unreal" _____
5. Depression _____
6. Numbness, burning, or tingling _____
7. Muscle aches _____
8. Muscle weakness or paralysis _____
9. Joint pain _____
10. Abdominal pain _____
11. Constipation _____
12. Diarrhea _____
13. Bloating _____
14. Troublesome vaginal discharge _____
15. Persistent vaginal burning or itching _____
16. Prostatitis _____
17. Impotence _____
18. Loss of sexual drive _____
19. Endometriosis _____
20. Premenstrual tension _____
21. Spots in front of eyes _____
22. Erratic vision _____

SECTION B TOTAL _____

SECTION C – OTHER SYSTEMS

Enter the appropriate score for each symptom below. If a symptom is *occasional* or *mild*, score **1** point. If a symptom is *frequent* or *moderately severe*, score **2** points. If a symptom is *severe* or *disabling*, score **3** points.

1. Drowsiness _____
2. Irritability or jitteriness _____
3. No coordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headaches _____
7. Dizziness/loss of balance _____
8. Pressure above ears, head tingling _____
9. Itching _____
10. Rashes _____
11. Heartburn _____
12. Indigestion _____
13. Belching and intestinal gas _____
14. Mucus in stools _____
15. Hemorrhoids _____
16. Dry mouth _____
17. Rash or blisters in mouth _____
18. Bad breath _____
19. Joint swelling or arthritis _____
20. Nasal congestion or discharge _____
21. Postnasal drip _____
22. Nasal itching _____
23. Sore or dry throat _____
24. Cough _____
25. Pain or tightness in chest _____
26. Wheezing or shortness of breath _____
27. Urgency or urinary frequency _____
28. Burning on urination _____
29. Failing vision _____
30. Burning or tearing of eyes _____
31. Recurrent infections or fluid in ears _____
32. Ear pain or deafness _____

SECTION C TOTAL _____

GRAND TOTAL SCORE _____

Your Grand Total Score will help determine if your health problems are yeast-connected.

Yeast-connected health problems are:	**Women**	**Men**
almost certainly present with scores over	180	140
probably present with scores over	120	90
possibly present with scores over	60	40

Women with scores less than **60** and men with scores less than **40** are less apt to have yeast-connected health problems.