ACUPUNCTURE WITH EASE

910-616-7330

NAME: _____

TODAYS DATE: _____

BIRTHDAY: _____

AGE: _____

GENDER: _____

ADDRESS: _____

CITY: _____

STATE: _____

ZIP: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

BEST NUMBER TO REACH ME (circle one):

HOME CELL WORK

EMAIL ADDRESS _____

HOW YOU FOUND OUT ABOUT US

_____

_____

_____

CIRCLE ONE:

married single partnered divorced widowed

SPOUSE/PARTNER: _____

CHILDREN (age and gender):

_____

_____

_____

_____

PHYSICIAN: _____

PHONE: _____

EMERGENCY CONTACT: _____

PHONE: _____

GOALS FOR ACUPUNCTURE TREATMENT:

_____

_____

_____

_____

_____

_____

MEDICATIONS/SUPPLEMENTS: (include all prescription and over the counter medications/supplements)

_____

_____

_____

_____

_____

_____

_____

What is your occupation? _____

Do you like your work? _____

How many hours do you work weekly? _____

How many servings per day to you use of the following?

coffee: _____ tea: _____ soft drinks: _____

alcohol: _____ water: _____

Cigarettes, cigars or other tobacco: _____

Frequency of use: _____

Any recreational drugs?: _____

List: _____

Describe your current diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Hours per week of formal exercise: _____

What kind of exercise:

_____

How many hours of sleep do you get a night? _____

Do you wake feeling rested? _____

Do you have trouble falling asleep? _____

Do you have trouble staying asleep? _____

For Women:

Age of first period: _____

Length of time between periods: _____

Painful periods: _____

Average number of days of flow: _____

Amount of flow (circle one): light normal heavy

Menopause age (if applicable):

Date of last pap smear: _____

Date of last mammogram: _____

Are you pregnant now? _____

Are you trying to become pregnant? _____

Number of pregnancies: _____

Number of live births: _____

If interested in fertility treatment, please describe any concerns and methods used to date:

_____

_____

_____

For Men:

1. Do you have any bothersome urinary or genital symptoms? (circle one) Yes No
2. Any sexual dysfunction? (circle one) Yes No

PAIN:

Are you experiencing pain/discomfort in any area of your body? (circle one)
Yes No

Where in your body?

For each body part, please indicate if the pain is: sharp/stabbing, pins and needles sensation, dull/aching, numb:

Please list all surgeries and the dates:

Please put a "C" in the blank for experiencing currently and a "P" in the blank for past experience.

General
____ trouble falling asleep
____trouble staying asleep
____ frequent nightmares
____ irritability
____ depression
____ mood swings
____fatigue
____ poor memory
____recent weight gain/loss
____cold hands or feet
____chills
____frequent fevers
____stress
____strong thirst
____low energy
____cancer

Head & Neck
____headaches
____migraines
____ stiff neck
____dizziness
____fainting/lightheadedness
____swollen glands

Ears
____glasses/contacts
____blurred vision
____poor night vision
____spots or floaters
____eye inflammation
____double vision
____Glaucoma
____Cataracts

Nose, Throat & Mouth:
____frequent sinus infections
____hay fever/allergies
____frequent sore throat
____difficulty swallowing
____mouth/lip sores
____frequent colds
____nosebleeds
____frequent nasal congestion
____excessive phlegm
____TMJ
____facial pain
____gum problems
____dry mouth

Skin/Hair
____hives
____rashes
____eczema/psoriasis
____night sweating
____excess sweating
____dry skin
____easy bruising
____changes in moles
____acne
____hair loss

Respiratory
____difficulty breathing when lying down
____wheezing
____asthma
____chronic cough
____wet cough
____dry cough
____coughing up blood
____shortness of breath
____tight chest
____Pneumonia
____painful breathing

Cardiovascular:
____high blood pressure
____low blood pressure
____chest pain or tightness
____palpitations
____rapid heartbeat
____irregular heartbeat
____swelling of body parts

Neurological:
___seizures
___tremors
___numbness or tingling
___paralysis
___poor coordination
___concussion
___lack of coordination
___loss of balance
___anxiety

Genitourinary:
___pain on urination
___frequent urination
___urgent urination
___unable to hold urine
___incomplete urination
___blood in urine
___wake to urinate
___increased libido
___decreased libido
___kidney stones
___impotence
___premature ejaculation
___pain/itching of genitalia
___lumps in testicles

Gynecological:
___irregular periods
___painful periods
___tender breasts
___lumps in breast
___pass clots in menstrual flow
___spotting
___ovarian cysts
___fibroids
___yeast infections
___vaginal discharge
___pain during intercourse
___fertility issues
___irregular pap smear

Cardiovascular Continued:
name locations of swelling:
___anemia
___heart attack
___blood clots

Gastrointestinal:
___nausea
___vomiting
___indigestion
___stomach pain
___diarrhea
___constipation
___poor appetite
___excessive hunger
___ulcer
___intestinal gas
___acid regurgitation/GERD
___bloating/belching
___bad breath
___chronic laxative use
___blood in stool
___mucus in stool
___hemorrhoids

Musculoskeletal:
___joint pain
___sore muscles
___weak muscles
___scoliosis
___shoulder pain
___upper back pain
___lower back pain
___rib pain
___limited range of motion
___cramping of body parts
___increased pain with hot or cold weather

Infection:
___HPV
___HIV
___Tuberculosis
___hepatitis
___Gonorrhea
___Chlamydia
___Syphilis
___genital warts
___genital herpes

Please list anything not previously mentioned that you believe is important for Kathy to know:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature _____

Date _____