I General Information

Name		Date	
Address	City	State	Zip
Date of Birth	Married Single Partner Divorced Widowed		
Home Phone	Cell Phone	Work Phone	
Email	Occupation		
Emergency Contact	Contact #		
Family Physician	May we contact them? Y / N	Contact #	
Referred By			
Have you had Acupuncture or Oriental medicine before? Y / N			
Are you presently under a doctor's care? Y / N	Who and for what?		
Are there any other therapies which you are involved?	Who and for what?		

II Focus

Are you Whole Body Health minded or do you only want to work on your main area of complaint?

○ Whole Body Health ○ Main Area of Complaint

What is your primary reason for seeking care at our office?

1. _____ What is your expectation? _____

2. _____ What is your expectation? _____

What was the initial cause?

What makes it worse?

What makes it better?

What have you done about this?

○ MRI ○ CT Scan ○ X-Rays ○ Blood Tests ○ Physical Therapy
○ Chiropractic ○ Massage Therapy ○ Pain Clinic ○ Pain Medicine
○ Other _____

_____

Has your condition been medically diagnosed? Y / N

List any other health challenges:

List any past or future surgeries:

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc.)

III Medical History

Do you have any allergies? Y / N If so, to what?

Do you take medication? Y / N If so, what types and how often?
*A listing from your pharmacy or primary care physician is very helpful.

Do you take supplements? Y / N If so, what types and how often?

Do you have any implanted medical devices?

- ○ Pacemaker
- ○ Defibrillator
- ○ Ventricular Assist Device
- ○ Cochlear Implants
- ○ Glucose Monitor
- ○ Insulin Pump
- ○ Other Drug Delivery Devices _____
- ○ Neuro Stimulators (Nerve / Brain / Gastric / Foot Drop) _____
- ○ Other _____

Please indicate if you currently have or had any of the following:

o Cancer	○ Drug Reaction	○ Mental Breakdown	○ Gonorrhea/Herpes	○ Mental Illness
○ Chemotherapy	○ Heart Attack	○ Jaundice	○ HIV/Aids	○ Hypo/hyper Thyroid
○ Taken Blood Thinners	○ Blood Transfusion	○ Parasites	○ High/Low Blood Pressure	○ Premature Graying
○ Diabetes	○ Anemia	○ Measles	○ Heart Disease	○ Seizures
○ Epilepsy	○ Arthritis	○ Mumps	○ Gout	○ Multiple Sclerosis
○ Kidney Stone	○ Obesity	○ Syphilis	○ Pneumonia	○ Other _____
○ Tuberculosis	○ Hepatitis			

Do you sleep well? Y / N Do you dream Y / N

Do you have a high point during the day? Y / N When?

Do you have a low point during the day? Y / N When?

Are you pregnant? Y / N Due Date? _____

On a scale of 0 – 10, how much do you believe your body can regain balance and heal itself? _____

*The services of an acupuncturist must not be regarded as diagnosis and treatment by a person licensed to practice medicine and must not be regarded as medical opinion or advice.

IV Patient Intake Organ Function

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a possible problem with that organ's function).

Lung Function / Large Intestine Meridian / Organ Network

- ○ Difficulty Breathing
- ○ Loose Stools
- ○ Dry Skin
- ○ Excess Phlegm
- ○ Tuberculosis
- ○ Sweating
- ○ Smoke (__ per day)
- ○ Sadness
- ○ Difficulty Concentrating
- ○ Frequent Colds/Flu
- ○ Psoriasis
- ○ Sinusitis
- ○ Shortness of Breath
- ○ Cough
- ○ Rapid, Quick Thinking
- ○ Slow Healing Skin
- ○ Pulmonary Diseases
- ○ Nasal Problems
- ○ Constipation
- ○ Melancholy
- ○ Asthma
- ○ Mucus in Stool
- ○ Diarrhea
- ○ Chest Congestion
- ○ Wheezing
- ○ Emphysema
- ○ Bottle fed as child
- ○ Allergies
- ○ Other _____

Sensitivities to: ○ Smells ○ Noise ○ Clothing ○ Energy ○ Other _____

Kidney / Urinary Bladder Meridian / Organ Network

- ○ Frequent Cavities
- ○ Memory Problems
- ○ Easily Startled
- ○ Sciatica
- ○ Diseases of the Spinal Column
- ○ Knee Pain
- ○ Heat in Chest
- ○ Unusual Urine out-put
- ○ Dental Problems
- ○ Excessive Hair Loss
- ○ Fatigue / Lethargy
- ○ Decreased Will Power
- ○ Osteoarthritis
- ○ Afternoon flushes
- ○ Lack of Perspiration
- ○ Ear/Hearing Problems
- ○ Kidney Stones
- ○ Frequent Night Urination
- ○ Cold Hands or Feet
- ○ Multiple Sclerosis
- ○ Infertility
- ○ Hot Body Temperatures
- ○ Perspire Easily
- ○ Easily Broken Bones
- ○ Lack of Bladder Control
- ○ Depression
- ○ Muscular Dystrophy
- ○ Sterility
- ○ Excessive Thirst
- ○ Hot Flashes
- ○ Low Back Pain
- ○ Fear
- ○ Premature Gray Hair
- ○ Cerebral Palsy
- ○ Cold Body Temperature
- ○ Night Sweats
- ○ Need Coffee/Caffeine boost in the morning

Liver / Gall Bladder Meridian / Organ Network

- ○ Anger Easily
- ○ Tightness in chest
- ○ Gall stones currently
- ○ Headaches on side of head
- ○ Liver Spots
- ○ Brittle/Course Nails or Hair
- ○ Cramping
- ○ Menstrual Cramping
- ○ Hiccups
- ○ TMJ
- ○ Frustration
- ○ Bitter Taste in Mouth
- ○ Seizure
- ○ PMS Symptoms
- ○ Substance Abuse
- ○ Distention/Bloating
- ○ Irritable Bowel
- ○ Vertigo
- ○ Belching
- ○ Stiff Neck & Shoulders
- ○ Depression
- ○ Tingling Sensations
- ○ Convulsions
- ○ Fibromyalgia
- ○ Chronic Fatigue
- ○ Flushed Face
- ○ Sensitivity to greasy foods
- ○ Tinnitus
- ○ Sour Regurgitation
- ○ Restless Legs
- ○ Irritability
- ○ Numbness
- ○ Skin Rashes
- ○ Nausea
- ○ Parkinson's Disease
- ○ Muscle Spasms
- ○ Migraines
- ○ Insomnia
- ○ Compulsion to Exercise
- ○ Anxiety Disorder
- ○ Pain in the Ribs
- ○ Gall Stones History
- ○ Crave Alcohol
- ○ Tendonitis
- ○ Migratory Pain
- ○ Twitching
- ○ Tremors
- ○ Staying Asleep
- ○ Sighing
- ○ Stroke

○ Repetitive Strain Disorders (Please list) _____

Heart / Small Intestine / Organ Network

- ○ Mental Confusion
- ○ Restlessness
- ○ Sores on Tip of Tongue
- ○ Drink Coffee __ # cups/day
- ○ Abdominal Pain
- ○ Phobias
- ○ Muscle Tone
- ○ Urinary Problems
- ○ Belching
- ○ Palpitations
- ○ Dizziness
- ○ Wake Unrefreshed
- ○ Dream Disturbed Sleep
- ○ Hot Flashes
- ○ Poor Circulation
- ○ Psychosis
- ○ Cardiac Pain
- ○ TMJ
- ○ Chest to Shoulder Pain
- ○ Vertigo
- ○ Difficulty Falling Asleep
- ○ Heart Problems
- ○ Hot Painful Joint
- ○ Rheumatoid Arthritis
- ○ Epilepsy
- ○ Shortness of Breath
- ○ Difficulty Staying Asleep
- ○ Flushed Face
- ○ Anxiety
- ○ Hearing Problems
- ○ Inflammatory Conditions
- ○ Tongue/Speech Problems
- ○ Spontaneous Sweating
- ○ Sour Regurgitation
- ○ Nightmares
- ○ Cold Limbs
- ○ Pain Down the Arm
- ○ Anemia
- ○ Disturbed Thinking
- ○ Lack of Joy/Humor
- ○ Upper Back Pain
- ○ Bitter Taste in Mouth

Spleen / Stomach Meridian / Organ Network

- ○ Low Appetite
- ○ Abrupt Weight Gain
- ○ Over-Thinking/Worry
- ○ Vomiting
- ○ Gurgling Noise in Stomach
- ○ Chronic Disease
- ○ Loose Stools
- ○ Difficulty Focusing
- ○ Insomnia
- ○ Excessive Appetite
- ○ Abrupt Weight Loss
- ○ Abdominal Bloating
- ○ Ulcer (diagnosed)
- ○ Cancer
- ○ Irritable Bowel
- ○ Non-Breast Fed
- ○ Hemorrhoids
- ○ Acid Reflux
- ○ Fatigue After Eating
- ○ Bad Breath
- ○ Belching
- ○ Burning Sensation After Eating
- ○ Diabetes
- ○ Weak Muscles
- ○ Fatigue
- ○ Excess Phlegm
- ○ Heartburn
- ○ Easily Bruised
- ○ Stomach Pain
- ○ Passing Gas
- ○ Prolapsed Organs
- ○ Gastritis
- ○ Headaches
- ○ Vein Problems
- ○ Crohn's Disease
- ○ Mouth Sores
- ○ Nausea
- ○ Nausea
- ○ Hiccups
- ○ Aching Heavy Limbs
- ○ Indigestion
- ○ Poor Memory
- ○ Bitter Taste in Mouth