



## PERSONAL LIFESTYLE HABITS

Cigarettes (packs): \_\_\_\_\_ Coffee/Tea (cups): \_\_\_\_\_ Alcohol (drinks/week): \_\_\_\_\_

Marijuana: \_\_\_\_\_ Other recreational drugs: \_\_\_\_\_

Vitamins & herbs: \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Food cravings: \_\_\_\_\_

### DIET - What you might eat on a typical day?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Type of Exercise: \_\_\_\_\_ How often: \_\_\_\_\_

What non-work activities do you enjoy doing? (Reading, TV, meditation, music, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICINES

Prescription drugs you are currently taking: \_\_\_\_\_

\_\_\_\_\_

For what condition(s): \_\_\_\_\_

\_\_\_\_\_

Current over-the-counter medication(s): \_\_\_\_\_

For what condition: \_\_\_\_\_

## MAJOR HOSPITALIZATIONS

If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: \_\_\_\_\_

Name of physician: \_\_\_\_\_

Physician address: \_\_\_\_\_

Physician phone: \_\_\_\_\_

Have you been treated with acupuncture or Chinese herbal medicine previously: yes \_\_\_ no \_\_\_

**CONSENT FOR TREATMENT:**

I, the undersigned, understand that acupuncture treatment involves the use of needles and may include acupressure, moxibustion, cupping, gua sha, and/or electrical stimulation. The risks, although limited, include puncturing organs in the abdomen and chest cavities, minor burns from moxibustion and bruising from gua sha or cupping techniques. Acupuncture may affect people on all levels including physical, mental, emotional and spiritual because it works with the whole body to create balance. The duration of the treatment varies from person to person depending on their specific illness and constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness of treatment after a specific treatment or series of treatments.

\_\_\_\_\_  
Patient's Signature (Parent or Guardian if Patient under age 18)

**Date:** \_\_\_\_\_

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

### General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

### Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

### Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

### Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

### Nose, Throat & Mouth

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems

Dry mouth

### Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

### Respiratory

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

### Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

### Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool

- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

### Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

### Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

### Genitourinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

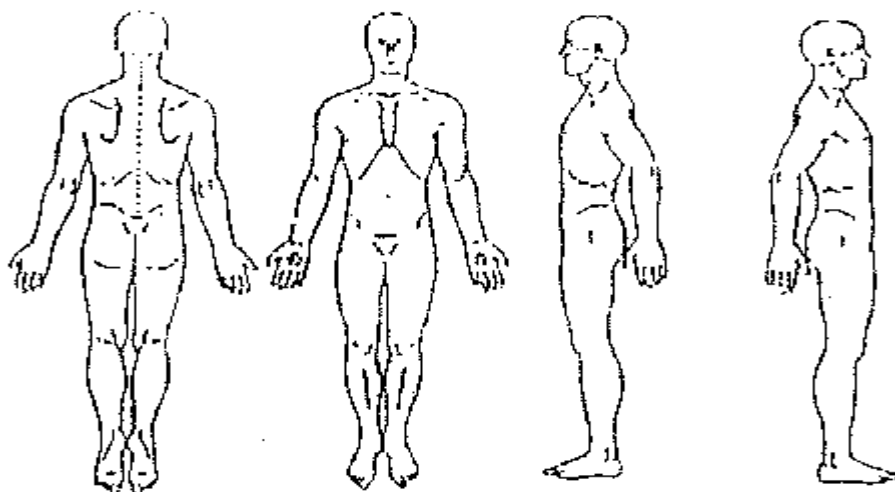
### Infection Screening

- IV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

Please mark areas of pain:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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