# ALAMEDA ACUPUNCTURE

Patient Name:_____ Date:____/____/____

Have you had Acupuncture before? ☐ Yes ☐ No - Did you have a positive ☐ Experience ☐ Outcome

Have you used Chinese Herbs? ☐ Yes ☐ No - Did you have a positive ☐ Experience ☐ Outcome

Comments about prior treatments_____

**Please indicate the severity of your symptoms at this time**

| | ⇓ Severe | ⇓ Moderate | ⇓ Slight | Major Complaints in order of ***Importance*** **to you Today** |
|---|---|---|---|---|
| 1. | ☐ | ☐ | ☐ | _____ |
| 2. | ☐ | ☐ | ☐ | _____ |
| 3. | ☐ | ☐ | ☐ | _____ |
| 4. | ☐ | ☐ | ☐ | _____ |
| 5. | ☐ | ☐ | ☐ | _____ |

What do you believe caused this problem? (Use numbers above)

1. _____
2. _____
3. _____
4. _____
5. _____

How long have you noticed symptoms of this problem?

1. _____
2. _____
3. _____
4. _____
5. _____

What is the diagnosis from your physician for this problem?

1. _____
2. _____
3. _____
4. _____
5. _____

What has been the prior treatment for this problem & who treated you for it?

1. _____
2. _____
3. _____
4. _____
5. _____

## Lifestyle and Medication Questions

**List vitamins and supplements that you take both regularly and occasionally**

| Supplement Name | Purpose | How Long Used | Dosage | How Often | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
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Initial:_____

| | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**List all pharmaceutical drugs you currently take, regularly & as needed (eg. Nose sprays)**

| Drug Name | Purpose | How Long Used | Dosage | How often | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**List all other pharmaceutical drugs taken in past six months**

| Drug Name | Purpose | How Long Used | Dosage | How Often | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Do you **NOW** follow a regular exercise program? ☐ Yes ☐ No Describe program. _____

_____

_____

Describe Your Typical Daily Diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Other: _____

How often do you use the following:

☐ Alcohol:_____drinks/week ☐ Tobacco:_____per day ☐ Sodas:_____/day

☐ Coffee:_____cups/day ☐ Tea: cups/day Tea type_____

## Family Medical History

Use a **C for a Current Problem** or a problem still present at the death of the individual indicated
Use an **H if it is a historical condition** that is not present now or was not present when person deceased
We understand that you may not be aware of these condition in many cases; leave these blank

| **Condition or Disease** ⇓ | Biological Father | Biological Mother | Spouse or Partner | Brother(s) | | Sister(s) | | Children | | |
|---|---|---|---|---|---|---|---|---|---|---|
| AGE of Individual ⇒ | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Hay fever/ Seasonal Allergy | | | | | | | | | | |
| Food Allergy / Sensitivity | | | | | | | | | | |
| Eczema | | | | | | | | | | |
| Psoriasis | | | | | | | | | | |
| Other Skin Disorder | | | | | | | | | | |
| Diabetes I - Juvenile | | | | | | | | | | |
| Diabetes II – Adult | | | | | | | | | | |
| Hyperthyroid or Graves Disease | | | | | | | | | | |
| Hypothyroid or Hashimotos | | | | | | | | | | |
| Osteoporosis or Bone Problems | | | | | | | | | | |
| Rheumatoid Arthritis | | | | | | | | | | |
| Other Arthritis or joint pain | | | | | | | | | | |
| Lupus or other Immune Disorder | | | | | | | | | | |
| Liver Disease | | | | | | | | | | |
| Hepatitis | | | | | | | | | | |
| Gallbladder Removed | | | | | | | | | | |
| Gallstones | | | | | | | | | | |
| Kidney Stones | | | | | | | | | | |
| Kidney disease | | | | | | | | | | |
| Heart Disease or problem | | | | | | | | | | |
| Stroke | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| Cholesterol problems | | | | | | | | | | |
| Cancer – Include Type | | | | | | | | | | |
| Digestive Disorder | | | | | | | | | | |
| Weight Problem | | | | | | | | | | |
| Anorexia, Bulemia, Eating Disorder | | | | | | | | | | |
| Crohns, Ulcerative Colitis, Colitis | | | | | | | | | | |
| Irritable Bowel | | | | | | | | | | |
| Chronic Constipation | | | | | | | | | | |
| Alcohol Abuse or Excess | | | | | | | | | | |
| Insomnia | | | | | | | | | | |
| Anxiety | | | | | | | | | | |
| Depression | | | | | | | | | | |
| Other:_____ _____ | | | | | | | | | | |

## Personal Medical

(Have you ***Ever*** experienced these Conditions? Please Explain.

☐ Allergy._____
☐ Diabetes_____
☐ Diagnosed with cholesterol problems_____
☐ High Blood Pressure_____ ☐ Low Blood Pressure:_____
☐ Seizures_____
☐ Thyroid disease _____
☐ Rheumatic Fever_____
☐ Stones (gallbladder / kidney)_____
☐ Heart disease _____

☐ Pacemaker or ☐ Heart Surgery_____
☐ Stroke/blood Clots _____
☐ Migraine Headaches _____
☐ Pneumonia/Bronchial/Lung Disease_____
☐ Sexually transmitted disease _____
☐ Hepatitis A / B / C / D or blood borne disease:_____
_____
☐ Other illness._____
_____
☐ Accident / trauma / surgery_____
_____
_____
Have you had any of these organs removed? If so please check box & give dates.
☐ Appendix_____ ☐ Gallbladder_____
☐ Tonsils and or adenoids_____ ☐ Uterus (hysterectomy)_____ ☐ Ovaries_____
☐ Other _____

**Your Current or Recent Health Problems:** check mark and explain )

☐ Poor or ☐ Excessive appetite _____
☐ Food cravings. Type of food?_____
☐ Weight gain or ☐ loss_____ # of lbs over what period of time?_____
☐ Excess thirst ☐ No thirst Do you generally drink ☐ hot ☐ cold_____
☐ History of, or current eating disorders_____
☐ Localized weakness_____
☐ Fatigue / low energy_____»Worst time of day: _____
☐ Fever / chills / temperature_____
☐ Sweat easily_____ ☐ Night sweats_____
☐ Tremors_____ ☐ Tics / spasms_____
☐ Other: _____
_____
_____

**Skin and Hair - current or recent**

☐ Rashes ☐ Itching ☐ Hives ☐ Dermatitis_____
_____
☐ Eczema_____
☐ Psoriasis_____
☐ Edema / fluid retention_____
☐ Pimples. Where?_____
☐ Hair loss_____ ☐ Dry hair_____
☐ Brittle nails or ridges_____ ☐ Skin Ulcers / sores / new moles_____
☐ Thinning skin_____ ☐ Bleeding or bruising_____
☐ Other:_____
_____

**Head, Eyes, Ears, Nose, Throat - current or recent**

☐ Glasses_____ ☐ Poor vision_____ ☐ Floaters/spots_____
☐ Dry eyes_____ ☐ Eye sensitivity_____ ☐ Sensitive to light_____
☐ Night blind_____ ☐ Blurry vision_____ ☐ Cataracts_____
☐ Eyestrain_____ ☐ Headaches_____ ☐ Glaucoma_____
☐ Concussion_____ ☐ Dizziness_____ ☐ Poor balance_____
☐ Earaches_____ ☐ Ear ringing_____ ☐ Ear discharge_____
☐ Poor hearing _____ ☐ Facial pain_____
☐ Sinus problems_____ ☐ Frequent sore throat_____
☐ Sore or swollen glands_____ ☐ Nose bleeds_____

☐ Sores on ☐ lips ☐ tongue ☐ mouth_____
☐ Teeth and gum problems_____
☐ Jaw clicking or TMJ_____ ☐ Grinding teeth_____
Other: _____
_____

**Gastro Intestinal – current or recent**

Bowel Movements: #_____x day ☐ Diarrhea_____ ☐ Constipation_____
☐ Blood in stools_____ ☐ Black stools_____ ☐ Floating stools_____
☐ Rectal pain_____ ☐ Hemorrhoids_____ ☐ Laxatives_____
☐ Nausea_____ ☐ Vomiting_____ ☐ Bad breath_____
☐ Belching_____ ☐ Gas_____
☐ Acid reflux_____ ☐ Indigestion_____
☐ Do you take antacid medication?_____
☐ Abdominal pain/cramps (Non menstrual)_____
☐ Crohns disease ☐ Ulcerative Colitis ☐ Irritable Bowel ☐ Other colon problems:_____
_____
Other:_____

**Genito-Urinary**

☐ Painful urination_____ ☐ Frequent urination_____
☐ Urgency_____ ☐ Unable to hold urine_____
☐ Wake to Urinate_____x per night Your typical urine color_____
☐ Decreased flow_____ ☐ Strong urine odor?_____
☐ Genital sores_____
☐ Erectile problems_____
☐ Lowered sex drive / How long?_____
☐ Other genital or urinary problems?_____
_____
_____

**Musculoskeletal**

☐ Neck pain_____
☐ Back pain_____
☐ Shoulder pain_____
☐ Elbow pain_____
☐ Forearm pain_____
☐ Hand wrist pain_____
☐ Hip pain_____
☐ Knee pain_____
☐ Foot/ankle pain_____
☐ General or other muscle pain_____
☐ Muscle weakness_____
☐ Other muscle or joint Problem:_____
_____
_____

**Cardiovascular**

☐ Chest pain_____ ☐ Blood clots_____
☐ Irregular heartbeat_____ ☐ Phlebitis_____
☐ High Blood Pressure_____ ☐ High blood pressure_____
☐ Difficult breathing / short of breath_____
☐ Fainting_____ ☐ Dizziness_____

☐ Cold hands _____ ☐ Cold feet _____
☐ Swollen hands _____ ☐ Swollen feet _____
☐ Other heart / circulation problems: _____
_____

## Respiratory

☐ Cough? Type & time of day _____
☐ Sinus drainage _____ ☐ Post nasal drip _____
☐ Sputum / phlegm _____ ☐ Color of sputum _____
☐ History of sinus Infection _____
☐ Asthma current _____
☐ Asthma history _____
☐ Bronchitis history _____
☐ Pneumonia history _____
☐ Difficult inhalation _____ ☐ Difficult breathing lying down _____
☐ Any other lung or breathing problems? _____
_____

## Neuro-psychological – History of any of these

☐ Seizures _____
☐ Dizziness _____
☐ Numbness or tingling _____
☐ Concussion _____
☐ Lack of coordination _____ ☐ Increased fear of falling _____
☐ Loss of balance _____
☐ Poor memory _____
☐ Bad temper or mood swings _____
☐ Anxiety _____
☐ Depression _____
☐ Easily susceptible to stress _____
☐ Have you ☐ are you currently seeing a Psychologist? _____
☐ Have you ☐ attempted or ☐ considered suicide? _____
☐ Any other neurological, emotional or psychological issues? _____
_____
_____

Is there anything else you want us to know about you? _____
_____
_____

## Women's Reproductive and Gynecology

**Please mark the items that are applicable and give any appropriate comments; such as the severity or length of time that the symptoms are present**

☐ Menopause: Age of Change: _____ Age @ 1st Menses _____

☐ Hot Flashes _____ ☐ Night sweats_____
Date last menstrual period started____/____/____Duration of period:_____days
Length of menstrual cycle (1st day of menses to 1st day of next menses)_____days
Color of Menstrual blood? ☐ Dark ☐ Pale ☐ Bright red ☐ Other_____
☐ Irregular periods_____ ☐ Clots_____
☐ Excessive bleeding_____ ☐ Light bleeding_____
☐ Other menstrual bleeding issues_____
☐ Abdominal cramps _____ ☐ Back pain with menses_____
☐ Breast tenderness or swelling _____
☐ Breast lumps or ☐ fibrocystic breasts _____
☐ Mammogram: Date / results of most recent_____
☐ Thermogram: Date / results of most recent_____
☐ PMS ☐ Mood swings ☐ Irritability ☐ Sadness ☐ Other changes in mood or psyche? _____
_____
☐ Changes in menses over past year _____
☐ Vaginal discharge? When_____Color_____Odor_____
☐ Vaginal or genital area itching_____
☐ Vaginal or genital area pain _____
☐ Uterine myomas / fibroids_____
☐ Ovarian cysts _____
# of Pregnancies_____# of Abortions or miscarriages_____# of Live births_____
Your children's current ages (and gender)_____
☐ I am considering having more children_____
☐ I would like to talk about Chinese Medicine for fertility_____
☐ Contraceptive use currently (type and duration)_____
☐ Birth control ever used (type and duration) _____
☐ Assisted reproductive technologies used ☐ IVF ☐ IUI ☐ Other:_____
_____
Other menstrual or reproductive Issues: _____
_____

Signature: _____ Date:_____