Absolute-cana Acupuncture Clinic

Patient Name _____ **Today's Date** _____
Marital Status _____ **Date of Birth** _____
Home Phone _____ **Age** _____ **Sex** _____
Work Phone _____ **Web-site** _____
Cell Phone _____ **Occupation** _____
Address _____

_____

Employer's Name & Phone # _____
Employer's Address _____
Have you Had Acupuncture Before? _____
Name of parent or guardian if under 18 _____
Emergency Contact person & phone # _____
Whom should we thank for referring you? _____
Physician's name _____ **Clinic** _____

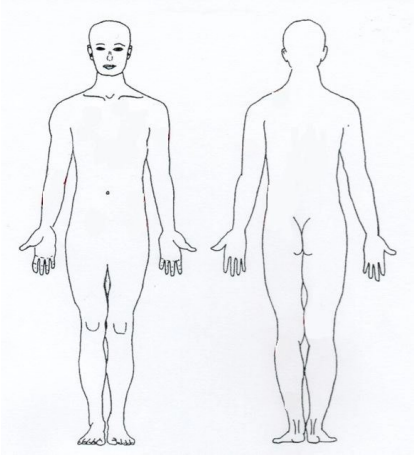
What are your goals for your health care here?

Just control the symptoms _____ **Keep the problem from recurring** _____

Please list the concerns that brought you here today in order of importance to you:

	Problem	**Date began/Slow or Quick Onset**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Please indicate where your symptoms are occurring:



Does the Condition(s) bother your: ☐**Sleep** ☐**Work** ☐**Other** _____

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What other treatments have you tried? _____

What medications are you currently taking? _____

_____

What dietary supplements do you take regularly? _____

_____

Family Medical History

☐ Allergies	☐ Congenital Disorders	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Neurological Disorders	☐ Thyroid Disorders
☐ Cancer	☐ Heart Disease	☐ Seizures	

Your Past Medical History

☐ Aids/HIV	☐ Emphysema	☐ Multiple Sclerosis	☐ Thyroid
☐ Alcoholism	☐ Epilepsy	☐ Mumps	☐ Tuberculosis
☐ Allergies	☐ Goiter	☐ Pacemaker	☐ Typhoid Fever
☐ Appendicitis	☐ Gout	☐ Pleurisy	☐ Ulcers
☐ Arteriosclerosis	☐ Heart Disease	☐ Pneumonia	☐ Venereal Disease
☐ Asthma	☐ Hepatitis	☐ Polio	☐ Whooping Cough
☐ Birth Trauma	☐ Herpes	☐ Rheumatic Fever	☐ Other (Specify)
☐ Cancer	☐ High Blood Pressure	☐ Scarlet Fever	_____
☐ Chicken Pox		☐ Seizures	_____
☐ Diabetes	☐ Measles	☐ Stroke	_____

Please describe any trauma or surgery you have had: _____

_____

Your Diet

Appetite	☐ Low	☐ Coffee	☐ Sugar	**Thirst For Water:**
	☐ High	☐ Soft Drinks	☐ Salty Foods	**#Glasses/day** _____
	☐ Irregular Eating		☐ Extreme Thirst	

Your Lifestyle

☐ Alcohol	☐ Marijuana	☐ Stress
☐ Tobacco	☐ Occupational Hazards	☐ Drugs

☐ Regular Exercise

Type _____ **Frequency** _____

Type _____ **Frequency** _____

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General Symptoms

- ☐ Recent Weight Gain/Loss
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Dream Disturbed Sleep
- ☐ Fatigue
- ☐ Lack of Strength
- ☐ Bodily Heaviness
- ☐ Cold Hands or Feet
- ☐ Feels Feverish
- ☐ Chills
- ☐ Night sweats
- ☐ Sweats Easily
- ☐ Muscle Cramps
- ☐ Vertigo/Dizziness
- ☐ Bleed or Bruise Easily

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses
- ☐ Tearing
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Floaters
- ☐ Poor Vision
- ☐ Blurred vision
- ☐ Night Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Tooth Ache
- ☐ Grinding Teeth
- ☐ TMJ
- ☐ Facial Pain
- ☐ Runny Nose
- ☐ Sores on lips/tongue
- ☐ Dry Mouth
- ☐ Excessive Saliva
- ☐ Sinus Problems
- ☐ Concussion
- ☐ Swollen Glands
- ☐ Lumps in Throat
- ☐ Enlarged Thyroid
- ☐ Nose Bleeds
- ☐ Ear Ringing
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Recurrent Sore Throat

Respiratory

- ☐ Difficulty breathing when lying down
- ☐ Tight Chest
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Asthma/Wheezing
- ☐ Pneumonia
- ☐ Coughing Blood

Cardiovascular

- ☐ Blood Clots
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Chest Pain
- ☐ Tachycardia
- ☐ Difficulty Breathing
- ☐ Heart Palpitations
- ☐ Irregular Heart Beat

Gastrointestinal

- ☐ Gas/Bloating
- ☐ Hiccup
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Mucous in Stools
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Nausea
- ☐ Acid Reflux
- ☐ Belching
- ☐ Poor Appetite
- ☐ Heavy Appetite

Bowel Movements:

Frequency _____ **Texture/Form** _____

Color _____ **Odor** _____

Musculoskeletal

- ☐ Muscle Pain
- ☐ Neck/Shoulder Pain
- ☐ Upper Back Pain
- ☐ Joint Pain
- ☐ Rib Pain
- ☐ Limited Range of Motion
- ☐ Limited Use
- ☐ Other _____

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Skin & Hair

☐ Rashes	☐ Itching	☐ Dandruff	☐ Changes in Hair & Skin
☐ Hives	☐ Ulcerations	☐ Hair Loss	☐ Acne
☐ Eczema	☐ Psoriasis	☐ Fungal Infections	

Neuropsychological

☐ Seizures	☐ Poor Memory	☐ Irritability	☐ Considered/ Attempted Suicide
☐ Numbnes	☐ Depression	☐ Easily Stressed	☐ Seeing a therapist
☐ Tics	☐ Anxiety/Panic	☐ Abuse Survivor	☐ Other(Specify)

Genito-urinary

☐ Painful Urination	☐ Venereal Disease	☐ Kidney Stone	☐ Urgent Urination
☐ Frequent Urination	☐ Bed Wetting	☐ Kidney Disease	☐ Blood in Urine
☐ Unable to Hold Urine	☐ Wake to Urinate	☐ Nocturnal Emission	☐ Impotence
☐ Straining to Urinate	☐ Decreased Sex Drive	☐ Increased Sex Drive	☐ Premature Ejaculation

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Gynecology

☐ Age Menses Began_____	☐ Irregular Periods	☐ Clots	☐ Age at Menopause _____
☐ Length of Cycle _____	☐ Painful Periods	☐ Breast Lumps	☐ Abortions
☐ #Days of Bleeding _____	☐ PMS	☐ # Pregnancies _____	☐ # Live Births _____
☐ Miscarriages	☐ Vaginal Discharge	☐ Vaginal Sores	☐ Vaginal Odor

Other

_____

_____

_____

_____

_____

_____