

Patient Name _____



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 Bloomsburg PA 17815
<http://www.FeelGoodAcupunctureHome.com>
 tel (570) 854-4745 fax (570) 784-3315

Date of Office Visit: _____

Patient Contact Information

Patient Name: _____ Phone: _____

Address: _____

If under 18, Name of Parent or Guardian: _____

Emergency Contact Information

Contact Name: _____ Phone: _____

Relation to Patient: _____

Primary Physician: _____ Phone: _____

General Patient Health Information

Date of Birth: _____ Age: _____ Gender: _____

Weight: _____ Height: _____

Occupation: _____

Have you ever received acupuncture before? Yes No

Have you ever received acupuncture at this office before, if yes, when? Yes No _____

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Main Complaint

What are you here to have treated today (Main Complaint)?

When did this complaint begin?

Under what circumstances did this complaint begin?

To what extent does this complaint interfere with your daily activities, such as sleep, work, mood or physical activity?

Where you given a medical diagnosis for this complaint? If yes, what?

What other treatments have you tried for this complaint?

Please list any other information that you feel is relevant to this complaint.

Medications

Please list all medications that you are taking and for what purpose.

Herbs and Supplements

Please list all herbs and dietary supplement that you are taking and for what purpose. Please also indicated if they are self-administered or prescribed by your physician or other health professional. If prescribed, please indicate by whom.

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Diet

How many meals a day do you eat?

Do you consistently eat meals at regular times of the day, or does it vary?

Please describe a typical day's meals:

Do you drink caffeinated beverages, if so what kinds and how frequently?

Do you drink alcohol, if so, in what quantities and how frequently?

Describe your daily fluid intake. Please list if this is in the form of water, sodas, fruit juices or other beverages.

Do you have any dietary restrictions? (low-carb, vegetarian, vegan, diabetic, religious)

Have you ever been diagnosed with an eating disorder? If yes, please list.

Exercise

Are you on a regular exercise program? If so please describe.

Family History

Please provide notes on any family health history that you think may be relevant to your health.

Energy Levels and Sleep

___ Energy Drop during day (what time _____) ___ General Fatigue ___ Difficulty falling asleep

___ Difficulty Staying Asleep ___ Disturbing dreams ___ morning grogginess

___ Night sweats ___ Sweats easily ___ Fevers ___ Chills

___ "runs hot" ___ "always cold"

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Pain

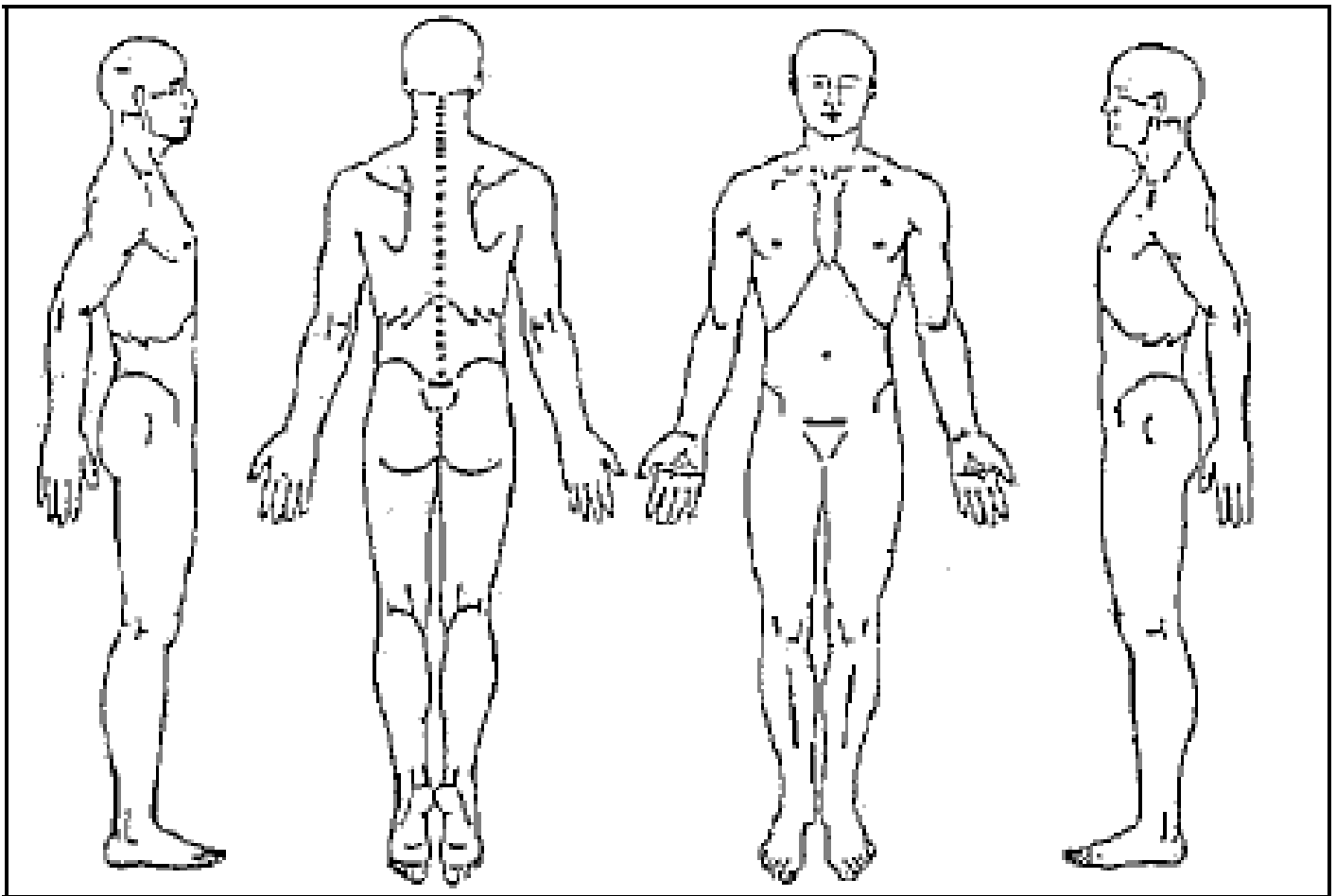
Please describe any pain or discomfort you experience and where. (Please also use the map below).

What is the quality of the sensation? (tingling, numbness, stabbing pain, aching pain, distending pain, alternating sharp and dull pain, pins and needles)

What makes it worse/better? (heat packs, ice, cold weather, damp weather, hot weather, exercise, rest)

Is it worse/better at any time of the day? (worse at night, in the morning, at the end of a work day)

Mark any areas of pain:



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Head, Ears, Eyes, Nose, Throat & Respiratory

Please check any of the following conditions that apply to you.

 tension headaches (forehead, temples, back of head, top of head, behind eyes) sinus headaches (forehead, cheeks, behind eyes) migraine headaches (forehead, temples(L/R/either), back of head, top of head, behind eyes) cluster headaches (list where: _____) history of head trauma, neck trauma or brain injury (please describe) facial pain (list where) bell's palsy trigeminal neuralgia stroke related facial dysymetry facial twitching Glasses Contact Lenses Blindness Visual Field Cut Eye Pain Cataracts Macular Degeneration (Dry/Wet) Blurred Vision Itchy eyes Dry eyes Watery Eyes Pressure Behind the Eyes Floaters Night Blindness Post Nasal Drip Allergic Rhinitis Chronic Sinusitis Frequent Sinus infections Frequent Nose bleeds Frequent Sneezing Snoring Deviated Septum Sleep Apnea Earaches Frequent Ear Infections Ear Discharge Dizziness Itchy Ears Ringing in Ears Deaf Hearing Loss Hearing Aid TMJ Jaw Clicks Teeth Clenching Teeth Grinding Frequent Cavities Bleeding Gums Bad Breath Mouth Ulcers Tongue Ulcers Sore Throats Hoarseness Dry Throat Dry Cough Productive Cough or Frequently Clearing ThroatAmount of Phlegm: abundant phlegm little phlegmColor of Phlegm: clear white yellow green grey/blackPresence of blood: yes no Asthma (Please indicate type of cough or wheezing if applicable) Wheezing Chest tightness Difficulty on exhalation Difficulty on inhalation Frequent Chest Colds Frequent Bronchitis Chronic Bronchitis

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- Current Smoker Former Smoker Emphysema Pain with breathing
 Difficulty breathing while lying down

Use this space to provide any additional information regarding the above checked conditions:

Digestive

Please check any of the following conditions that apply to you.

- Poor Appetite Gnawing Hunger Excessive appetite Chronic overeater
 weight gain weight loss Food Cravings (sweet, sour, salt, bitter, spicy, other _____)
 Prefer hot drinks Prefer cold drinks
 # Bowel Movements per day OR # Bowel Movements per week
 Diarrhea(urgent, with cramping) Diarrhea(chronic) loose stools
 Sluggish bowel movements (frequently feeling "incomplete") Constipation
 Dry stools Sticky Stools Hard Stools Difficult to pass stools
 Color of stools if not brown (black, grey, green, orange, clay-colored, other: _____)
 Mucous in stools Blood in stools Hemorrhoids Chronic laxative use
 Stomach Ulcers Duodenal Ulcers Ulcerative Colitis Irritable Bowel Syndrome
 Chron's Disease Diverticulitis Fistulas Fissures
 Colorectal surgery: _____
 Acid reflux Burping Indigestion Bloating
 Vomiting Nausea
 Food Allergies (list, specify reaction and specify if anaphylaxis is an exposure risk)

Use this space to provide any additional information regarding the above checked conditions:

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Cardiovascular

Please check any of the following conditions that apply to you.

- High blood pressure (List typical reading _____) Low blood pressure (List typical reading _____)
 Heart Attack Stroke Irregular Heart Rhythm (provide diagnosis _____)
 Cold Hands/Feet Swelling Hands/Feet Blood clots Bruises easily
 Bleeding or Clotting disorder (list _____)
 Angina Shortness of breath Anemic Stroke

Please use this space to explain any of the above conditions:

Endocrine

Please check any of the following conditions that apply to you.

- Hypothyroid Hyperthyroid Goiter Thyroid/Parathyroid Surgery
 Thyroid Replacment Hormone Hyperparathyroidism Hypoparathyroidism
 Adrenal disorders/diseases/surgeries (please list):
 Insulin Dependent Diabetes Adult Onset Diabetes Childhood Diabetes
 Diabetic complications (please list)

Neuro-psychological

Please check any of the following conditions that apply to you

- Depression Anxiety Frustration Bad Temper
 Panic Disorder Easily Stressed Receiving Psych. Treatment
 Considered Suicide Attempted Suicide Post Traumatic Stress Disorder
 Poor Memory Memory Loss Concussion Lack of Coordination
 Paralysis Numbness Nerve-related pain

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Skin & Hair

Please check any of the following conditions that apply to you. For skin disorders, specify where.

- Hair Loss prematurely gray dry hair dandruff
 moles skin cancer ulcerations lesions
 eczema psoriasis rashes itching
 flaking acne Changes in skin/hair texture

Urinary

Please check any of the following conditions that apply to you and answer any questions

- Urination Pain Blood in Urine Cloudy Urine Frequent Urinary Tract Infections
 Kidney Stones Frequent Urination Waking up to urinate more than 1 time/night
 Urinary Urgency with normal urine flow Urinary urgency with little urine flow
 Decreased urinary flow or stream Color of urine (clear, yellow, dark yellow/brown)
 Do you take vitamins that may affect the color of your urine? _____ Urinary incontinence
 Enlarged Prostate Prostate cancer Prostate surgery

Reproductive (Male)

Please check any of the following conditions that apply to you

- Impotency due to medication Impotency due to other causes(list, if known) _____
 Infertility
 sperm morphology sperm motility sperm production
 unknown/other please describe

Reproductive (Female)

Please check any of the following conditions that apply to you and answer any questions

- _____ Age of menarche (first menstruation) (write NA if patient has not had first period)
 _____ Age of menopause (write NA if patient has not reached menopause)

Please describe **your average menstrual cycle**:

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(When asked "which days", "day 1" of your cycle is the first day of bleeding)

___ Number of days of complete cycle ___ Number of days bleeding

___ spotting before period ___ spotting at ovulation ___ ovulation pain

___ period stops and starts ___ cramping prior to period (when) _____

___ cramping on first couple of days of period (___ mild, ___ moderate, ___ severe)

___ cramping after period (___ mild, ___ moderate, ___ severe)

___ Heavy flow (unusually frequent protection change to avoid risk of leaking, or possibly using more than one form of protection, i.e. - super tampon + super pad worn together). (which days? _____)

___ Fibroids ___ endometriosis

___ Regular flow (little risk of leakage during the daytime if changing protection every 3-4 hours, normal protection - regular pads or tampons) (which days? _____)

___ Light flow (little or no protection needed) (which days? _____)

___ brown menstrual blood (which days? _____)

___ purplish menstrual blood (which days? _____)

___ fresh red menstrual blood (which days? _____)

___ bright or orange menstrual blood (which days? _____)

___ pink or pale menstrual blood (which days? _____)

___ pea-sized or smaller clots (which days? _____)

___ larger than pea-size clots (which days, what color, what size, with cramping?

_____)

The above was a description of your average menstrual cycle. Have you been experiencing irregularities in your cycle? _____

If yes, using the above categorizations, please list how your cycles have been deviating. (Example, changes in color, number of days between bleeding, number of days bleeding, etc.)

Are you taking any medications that regulate your menstrual cycle? If yes, please list:

Have you ever been pregnant? _____ # of live births? _____

of miscarriages _____ Are you trying to get pregnant now? _____

Is there any chance you could be pregnant now? _____

If you have children now, how many and what ages? _____

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Premature deliveries (#, how early)? _____

Cesarian deliveries (#, why?) _____

Late deliveries or induced labor? (#, how late) _____

___ Pregnancy complications

___ Preclampsia ___ Gestational diabetes ___ threatened miscarriage

___ hyperemesis ___ other ___ hemorrhaging (during or after pregnancy)

___ ectopic pregnancies

___ Post pregnancy complications

___ Uterine prolapse ___ changes in menstrual cycle (see above)

___ bladder prolapse ___ stress incontinence ___ post-partum depression

___ secondary infertility (see below)

___ Tubal Ligation ___ Hysterectomy (complete) ___ Hysterectomy (ovaries left)

___ Female infertility:

___ blocked fallopian tubes ___ Polycystic ovary syndrome ___ age related hormonal decline

___ amenorrhea ___ irregular cycle, irregular ovulation

___ other/more specific diagnosis (please provide)

___ if unknown, how long have you been trying _____

___ Vaginal discharge

(___ white, ___ yellow, ___ green: how long _____, cycle related? Which days? _____)

___ cervical dysplasia ___ frequent yeast infections

___ Herpes ___ HIV/AIDS ___ other STDs _____

___ Menopausal complaints (symptoms started with menopause)

___ irritability ___ frustration ___ fatigue ___ hot flashes ___ night sweats ___ other(list)