COMPREHENSIVE ACUPUNCTURE EXAMINATION

Note: All information in this questionaire is confidential

Name_____ Date_____ Phone: Wrk_____ Home_____
Address_____ City_____ State_____ Zip Code_____
Occupation_____ Birth Date_____ Age_____ Height_____ Weight_____
How I Found Out About Your Office_____ Family MD _____

Major Complaint/s_____

_____

_____

Other Complaint/s_____

_____

Date of onset (first noticed your problem)?_____How long have you had this condition?_____
Have you had this previously in the past? [ ] Yes [ ] No When? _____
What makes it better? _____ What makes it worse? _____
Other symptoms that accompany this problem:_____
Is this condition: [ ] Getting worse [ ] Constant [ ] Comes and Goes
Medications/Drugs/Herbs you are currently taking: _____

_____

Other treatments you have tried for this condition:_____

_____

MEDICAL HISTORY: Date of your last physical exam_____ By Whom_____
List major surgeries/accidents/hospitalizations you have had and dates:_____

_____

_____

Do you have or have you ever had: [ ] Allergies [ ] Arthritis [ ] Asthma [ ] Anemia [ ] Heart Trouble
[ ] Cancer [ ] Kidney or bladder trouble [ ] Gallstones [ ] Ulcers [ ] Chronic Fatigue
[ ] Hepatitis [ ] Jaundice [ ] Sudden Weight loss [ ] Sudden Weight gain
Other:_____
* If allergies, please complete back of second page

FAMILY HISTORY: Has any member of your family had any of the above? [ ] Yes [ ] No
If yes, which member and what did they have?_____

_____

ENERGY LEVEL: [ ] High [ ] Enough [ ] Low What depletes your energy? _____

STRESS: [ ] None [ ] Moderate [ ] Severe What causes it?_____
If you could change one thing in your life, it would be?_____ _____

Check off any that has occurred in the last 3 months.
SWEATING: [ ] Night sweats [ ] Rarely sweat [ ] Spontaneous sweats [ ] Excess sweating

CIRCULATION: Feelings of [ ] Hot [ ] Cold What area?_____
[ ] Bleed easily [ ] Cold limbs Other_____

SKIN: [ ] Dry [ ] Itchy [ ] Moist/clammy [ ] Burning [ ] Changing moles or lumps [ ] Boils
[ ] Frequent rashes [ ] Acne [ ] Hair loss/thinning [ ] Dry scalp [ ] Skin puffy/wrinkled
[ ] Bruises easily [ ] Hives Other:_____

SCARS: (List all scars from accidents or surgeries)_____

_____

SLEEP PROBLEMS: [ ] Trouble falling asleep [ ] Trouble staying asleep [ ] Don't feel rested
[ ] Excess dreaming Other:_____

HEAD: [ ] Headaches (what area?)_____ [ ] Dizziness [ ] Memory loss
[ ] Loss of balance Other_____

EYES: [ ] Eye pain [ ] Dry eyes [ ] Blurred vision [ ] Cataracts [ ] Night blindness
Other:_____

EARS: [ ] Poor hearing [ ] Earaches [ ] Ear discharge/infections [ ] Ringing/buzzing in ears
Other:_____

NOSE: [ ] Frequent nose bleeds [ ] Sinus trouble [ ] Frequent colds Other:_____

THROAT: [ ] Sore throat [ ] Hoarseness [ ] Difficulty swallowing [ ] Jaw problems [ ] Grind teeth
[ ] Teeth/gum problems [ ] Swollen tongue Other:_____

CHEST: [ ] Hard to breathe [ ] Wheezing [ ] Shortness of breath [ ] Mucous rattles when breathing
[ ] Trouble breathing at night [ ] Pain/Pressure in chest [ ] Palpitations [ ] Persistant cough
[ ] Coughing blood [ ] Coughing phlegm Sputum color_____ Consistency_____
Other:_____

BLOOD PRESSURE: [ ] High [ ] Low [ ] Do not know

BOWELS: [ ] Diarrhea [ ] Constipation [ ] Bloody stools [ ] Black stools [ ] Mucus in stool
[ ] Hemorrhoids [ ] Rectal pain [ ] Gas [ ] Colon problems Number of bowel movements a day_____
Other:_____

URINE: Color_____ Amount/volume_____ [ ] Frequent urination
[ ] Strong smelling urine [ ] Hard to urinate [ ] Pain or burning on urinating [ ] Blood in urine
[ ] Urgency to urinate [ ] Unable to hold urine [ ] Wake at night to urinate [ ] Water retention
[ ] Frequent infections Other:_____

MUSCULOSKELETAL: Pain in: [ ] Neck [ ] Shoulder [ ] Arms/hands [ ] Wrists [ ] Hip
[ ] Knee [ ] Back [ ] Swollen joints [ ] Bones sore/painful [ ] Weakness in legs or knees
[ ] Ankles [ ] Stiff all over [ ] Muscle spasm/cramps [ ] Loss of feeling in hands/feet [ ] Bursitis
Other:_____

NEUROLOGICAL: [ ] Nervousness [ ] Depressed [ ] Easily Angered [ ] Easily Irritated
[ ] Frequent crying [ ] Worry/Anxiety [ ] Mood swings [ ] Poor memory [ ] Poor concentration
[ ] Suicidal [ ] Tremors [ ] Numbness/tingling in limbs [ ] Poor coordination [ ] Muscle weakness
[ ] Feel weak and shaky [ ] Seizures [ ] Neuralgia (nerve pain) [ ] Shingles

FEMALES: Pregnant? [ ] Yes [ ] No Last monthly period_____ Last PAP test_____
Form of birth control: [ ] None [ ] Pill Other:_____
Age started menstrual cycle_____ Age stopped_____ Is your period regular? [ ] Yes [ ] No
What color best describes your flow? [ ] Pale [ ] Red [ ] Bright red [ ] Dark Clots? [ ] Yes [ ] No
What is the usual interval? _____ Is the volume [ ] Heavy [ ] Light

Do you feel tired and fatigued [ ] Before [ ] During [ ] After your period?
Do you feel worst [ ] Before [ ] During [ ] After your period?

Do any of the following symptoms occur in cycle with your period?
[ ] Low backache [ ] Bloating [ ] Moody [ ] Irritable [ ] Headache [ ] Low sex drive
[ ] Tender breasts [ ] Hot flashes [ ] Food cravings Other:_____

Do you often experience vaginal infections? [ ] Yes [ ] No
Discharges: [ ] Yellow [ ] Thick [ ] White [ ] Odor [ ] Itching [ ] Liquid Other:_____

# of Pregnancies_____ # of Deliveries_____ # of Miscarriages_____ # of Abortions_____
# of Cesareans_____ Operations [ ] Cervix [ ] Uterus [ ] Ovaries Other:_____

MALES: [ ] Low sexual drive [ ] Lack of sexual drive [ ] Impotence [ ] Ejaculation causes pain

[ ] Discharges [ ] Premature ejaculation [ ] Prostate trouble
Other:_____

APPETITE: [ ] Excessive appetite [ ] Poor appetite [ ] Appetite keeps changing [ ] Weak if meal missed
[ ] Excessive thirst [ ] Never thirsty Other:_____
Any specific food cravings?_____

DIGESTION: [ ] Stomach gas [ ] Heartburn [ ] Belching [ ] Abdominal pain or cramps
[ ] Abdominal bloating [ ] Bitter/sour taste in mouth [ ] Nausea [ ] Vomiting [ ] Sores in mouth
[ ] Indigestion [ ] Food Allergies...to what?_____ Other:_____

NUTRITION: List what you ate yesterday_____
List foods you eat the most of:_____
List foods you eat the least of:_____

How many meals a day do you eat?_____ What is your biggest meal?_____
Do you eat when you are worried or rushed? [ ] Yes [ ] No How often?_____
Do you drink coffee or caffeinated tea? [ ] Yes [ ] No _____Cups/Day
Do you drink alcohol? [ ] Yes [ ] No _____Drinks/week What type_____
Smoke cigarettes? [ ] Yes [ ] No _____ Amt. per day
Have you ever been drug or alcohol dependent? [ ] Yes [ ] No When_____

EXERCISE: What types of exercise do you presently participate in? How often?
1._____ 2._____ 3._____

FUNCTIONAL /PAIN ASSESSMENT:

IF YOU HAVE ANY PAIN CONDITION PLEASE COMPLETE THE FOLLOWING:

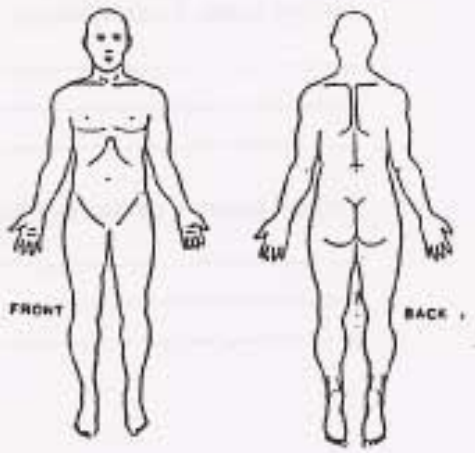
Please rate your average pain intensity, on a scale of 0 - 10 with 0 = no pain and 10 = the worst pain imaginable. If there is more than one area, please list each separately.

BODY AREA_____ #____ BODY AREA_____ #____ BODY AREA_____ #____

When you have pain, which of the following activities does your pain affect? Please mark an "X" in the box which best describes to what extent these activities become difficult:

ACTIVITY	Never Difficult	Sometimes Difficult	Frequently Difficult	Always Difficult
Sleep				
Sports				
Schoolwork				
Eating				
Job				
House Chores				
Driving				
Walking				

On the diagrams below, please shade in the areas where you experience pain.



DATE:_____ PATIENT SIGNATURE_____

ALLERGY HISTORY

Main Symptoms and frequency of their occurrence, time of day/year, etc.:

_____

_____

_____

_____

_____

Symptoms are: [ ] constant [ ] getting worse

When did your allergy symptoms first start (age)? (Can you recall circumstances surrounding and immediately preceding on the onset of symptoms?....i.e. change diet, eat something you don't normally eat, have a recent illness or life-altering event, etc.

_____

_____

_____

_____

Medicine/supplements you use to control your symptoms:

_____

_____

_____

Allergies/symptoms in family: (i.e., asthma, hay fever, skin rashes, etc.)

_____

_____

Reactions when eating certain foods : (Indigestion, heartburn, reflux, gas, bloating, runny nose, constipation, diarrhea, etc.)

_____

_____

_____

Other known or suspected substances that you are allergic to:

_____

_____

_____

Acupuncture Associates
59 Merriam Avenue
Leominster, MA 01453
978-534-5388