Inner Court Acupuncture

Name_____ Today's Date _____/_____/_____

Address _____

Home ph._____ Work ph._____e-mail_____

Birthdate ____/ ____/ ____ Marital Status ____Single____Married / Partnered ____Divorced ____Widowed

Occupation _____ Any children?_____

Emergency contact _____ Phone _____

Had acupuncture before? Y / N Reason for visit today _____

How long have you had this condition?_____ Onset was sudden / gradual

What was the initial cause?_____ Is it getting worse? _____

What makes it better? _____ Worse? _____

Does it bother your: ____Sleep ____Work ____Activities ____Mood Level of Pain (1 – 10) _____

Any medical diagnosis received? _____

Who is your physician? _____ Phone _____

Family Health History

❑ Allergies
❑ Arteriosclerosis
❑ Asthma
❑ Alcoholism/Drug Abuse
❑ Cancer
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ Intestinal Disorder
❑ Psychiatric Condition
❑ Seizures
❑ Stroke
❑ Other _____

Your Health History

❑ Aids/HIV
❑ Alcohol/Drug Abuse
❑ Allergies
❑ Anemia
❑ Appendicitis
❑ Arteriosclerosis
❑ Asthma
❑ Birth trauma
❑ Bronchitis
❑ Cancer
❑ Chicken Pox
❑ Colitis/IBS
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Gallstones
❑ Gout
❑ Hepatitis
❑ Herpes
❑ High / Low Blood Pressure
❑ Lyme Disease
❑ Mitral Valve Prolapse
❑ Multiple Sclerosis
❑ Pacemaker
❑ Pleurisy
❑ Pneumonia
❑ Polio
❑ Rheumatic Fever
❑ Rheumatoid Arthritis
❑ Reynaud's Disease
❑ Scarlet Fever
❑ Seizures
❑ Shingles
❑ Stroke
❑ Thyroid Disorder
❑ Tuberculosis
❑ Ulcers
❑ Venereal Disease
❑ Whooping Cough
❑ Other _____

List Surgeries: _____
_____
_____
_____

List Major Traumas:
_____
_____
_____
_____

Your Diet

❑ Appetite Low
❑ Appetite High
❑ Caffeinated drinks
❑ Soft Drinks
❑ Artificial Sweetener
❑ Crave sugar/starches
❑ Crave salty foods
❑ Vegetarian

# of glasses of water per day _____

Average Daily Menu

Breakfast _____ Lunch_____ Dinner _____ Snacks_____
_____ _____ _____ _____
_____ _____ _____ _____

Pharmaceuticals taken in last 2 months:_____
_____

Vitamins/herbs/supplements taken in last 2 months: _____
_____

(over)

Your Lifestyle

❑ Alcohol
❑ Tobacco
❑ Marijuana
❑ Drugs
❑ Stress
❑ Occupational hazards
❑ Regular exercise

General Symptoms

❑ Tend to feel hot
❑ Tend to feel cold
❑ Recent weight loss / gain
❑ Insomnia
❑ Heavy sleep
❑ Dream-disturbed sleep
❑ Fatigue
❑ Body feels heavy
❑ Cold hands or feet
❑ Poor circulation
❑ Frequent fever
❑ Chills
❑ Night sweats
❑ Sweat easily
❑ Muscle cramps
❑ Tremors/shaking
❑ Vertigo or dizziness
❑ Bleed or bruise easily
❑ Peculiar taste_____

Head, Eyes, Ears, Nose, Throat

❑ Eye pain
❑ Red/itchy eyes
❑ Spots in eyes
❑ Blurred vision
❑ Night blindness
❑ Teeth clenching/grinding
❑ TMJ
❑ Facial pain
❑ Gum problems
❑ Sores on lips or tongue
❑ Dry mouth
❑ Sinus problems
❑ Nose bleeds
❑ Excessive phlegm/mucus
Color _____
❑ Recurrent sore throat
❑ Swollen glands
❑ Lumps in throat
❑ Ringing in ears
❑ Earaches
❑ Poor hearing
❑ Headaches
❑ Migraines
❑ Concussions

Other head or neck problems:
_____
_____
_____

Respiratory

❑ Shortness of breath
❑ Tight chest
❑ Asthma/wheezing
❑ Frequent colds/flus
❑ Coughing blood
❑ Cough

Wet or dry? _____
Color of phlegm _____

Cardiovascular

❑ Blood clots
❑ Fainting
❑ Chest pain
❑ Difficulty breathing
❑ Tachycardia
❑ Heart palpitations
❑ Phlebitis
❑ Irregular heartbeat

Gastrointestinal

❑ Nausea/vomiting
❑ Acid reflux
❑ Hiatal hernia
❑ Gas
❑ Bloating
❑ Bad breath
❑ Feel tired after eating
❑ Intestinal pain/cramping
❑ Diarrhea
❑ Regular loose stools
❑ Constipation
❑ Laxative use
❑ Black stools
❑ Bloody stools
❑ Mucus in stools
❑ Itchy/burning anus
❑ Hemorrhoids/fissures
❑ Eating disorder

Bowel movements:
Frequency _____
Form _____
Color _____

Musculoskeletal/Neural

❑ Neck/shoulder pain
❑ Upper back pain
❑ Low back pain
❑ Hip pain
❑ Knee pain
❑ Ankle pain/sprain
❑ Herniated discs
❑ Sciatica
❑ Osteoarthritis
❑ Fibromyalgia
❑ Chronic Fatigue Syndrome

Other _____
_____

Skin and Hair

❑ Rashes
❑ Hives
❑ Ulcerations
❑ Eczema
❑ Psoriasis
❑ Acne
❑ Dandruff
❑ Itching
❑ Hair loss
❑ Dry skin

Other skin/hair issues ____
_____

Neuropsychological

❑ Seizures
❑ Numbness
❑ Tics
❑ Poor memory
❑ Periods of depression
❑ Frequent anxiety
❑ Easily irritable
❑ Easily stressed
❑ History of abuse
❑ Seeing a therapist

Other _____
_____

Genito-Urinary

❑ Pain on urination
❑ Frequent urination
❑ Urgent urination
❑ Unable to hold urine
❑ Incomplete urination
❑ Wake to urinate
❑ Blood in urine
❑ Infertility
❑ Increased libido
❑ Decreased libido
❑ Impotence
❑ Premature ejaculation
❑ Nocturnal emission
❑ Kidney stones
❑ Prostate condition

Gynecological

❑ Vaginal discharge
Color _____
❑ Vaginal sores
❑ Vaginal odor
❑ Breast lumps
❑ Fibroids/cysts

# of pregnancies _____
# of births_____
❑ Menopausal symptoms
Age of menopause _____
Age menses began _____
# of days of flow_____

Length of cycle _____
❑ Irregular periods
❑ PMS
❑ Painful periods
❑ Clotting with flow
❑ Amenorrhea

Date of last PAP _____

Are you pregnant or trying to get pregnant? Y / N

What are you hoping to achieve with treatment? _____

_____

_____