
What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

Personal History Please check any conditions or symptoms you have now.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility <input type="checkbox"/> Emphysema | |

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- | | | | |
|--|--|---|-------------------------------------|
| <input type="checkbox"/> Diabetes ___ | <input type="checkbox"/> Seizures ___ | <input type="checkbox"/> Heart Disease ___ | <input type="checkbox"/> Stroke ___ |
| <input type="checkbox"/> High Blood Pressure ___ | <input type="checkbox"/> Allergies ___ | <input type="checkbox"/> Cancer ___ <input type="checkbox"/> Asthma ___ | |
| <input type="checkbox"/> Other _____ | | | |

Please check if you have had any of these items listed below in the last year

Put a star on the box if you had this in the past but do not any longer.

General

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily <input type="checkbox"/> Tremors | |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance <input type="checkbox"/> Change in appetite | |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) | |

Skin and Hair

- | | | | |
|---|--------------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair <input type="checkbox"/> Recent moles | |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Headaches |

Cardiovascular

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Dizziness | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Production of phlegm... what color? _____ | |

Gastrointestinal

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |

Genito-Urinary

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ | | <input type="checkbox"/> Excessive libido | |

Gynecological/Reproductive

- | | | |
|--|--|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses _____ |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses _____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Number of pregnancies _____ |

- Infertility
 - Polycystic Ovarian Disease
 - Number of ectopic pregnancies _____
 - Irregular menstruation
 - PMS
 - Number of live births _____
 - Painful menstruation
 - Number of miscarriages _____
 - Number of abortions _____
- Do you practice birth control? _____
- What type? _____ How long? _____

Musculoskeletal

- Neck pain
- Shoulder pain
- Hand/wrist pain
- Carpal Tunnel
- Knee pain
- Sprains/Strains
- Sciatica
- Foot/ankle pain
- Hip pain
- Muscle pain
- Muscle weakness
- Tendonitis
- Back pain Low__ Middle__ Upper__
- Bursitis
- Rotator Cuff
- Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

- Seizures
- Loss of balance
- Vertigo/Dizziness
- Areas of numbness
- Lack of coordination
- Poor memory
- Concussion
- Depression
- Anxiety/Panic attacks
- Bad temper/irritable
- Easily susceptible to stress
- Seasonal Affective Disorder
- Nervousness
- ADD/ADHD
- Manic Depression

- Have you ever been treated for emotional problems? Yes No
- Have you ever considered or attempted suicide? Yes No
- Have you ever been treated for substance abuse? Yes No

Comments Please inform me of any other problems you would like to discuss.

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, acupresure, Chinese or Western herbal medicine, and nutritional counseling.

Ann may also incorporate her training in Trager, yoga, crainiosacral therapy and meditation

As appropriate into a session.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____

initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____

Patient's Name

Patient's Signature

Date Signed

Are you Pregnant?

Name of Patient _____

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Patient's Representative _____

Relationship or Authority of Patient _____

Witness _____

Name of Licensed Acupuncturist