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Natural Medicine for the Entire Family™

PERSONAL INFORMATION

NAME_____ DATE _____

AGE_____ DATE OF BIRTH _____MARITAL STATUS_____

ADDRESS_____CITY_____ STATE_____ZIP_____

HOME PHONE _____CELL PHONE_____WORK PHONE_____

EMAIL ADDRESS_____# OF CHILDREN _____

HEIGHT_____WEIGHT_____PREGNANT NOW_____

OCCUPATION_____EMPLOYER_____

WHO REFERRED YOU _____

EMERGENCY NOTIFICATION

NAME _____RELATIONSHIP_____

TELEPHONE_____EMAIL_____

CURRENT HEALTH CONCERNS

LIST HEALTH CONCERNS IN ORDER OF IMPORTANCE:

	Rate Severity 1 = Mild 10 = Worst Imaginable	Date started, for how long?	If you had the condition before, when?	What irritates the condition?	Worse at certain times of day?
1.					
2.					
3.					
4.					
5.					

WHAT HAVE YOU DONE FOR THESE CONDITIONS? WAS IT OF BENEFIT?

_____

_____

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING ACTIVITIES

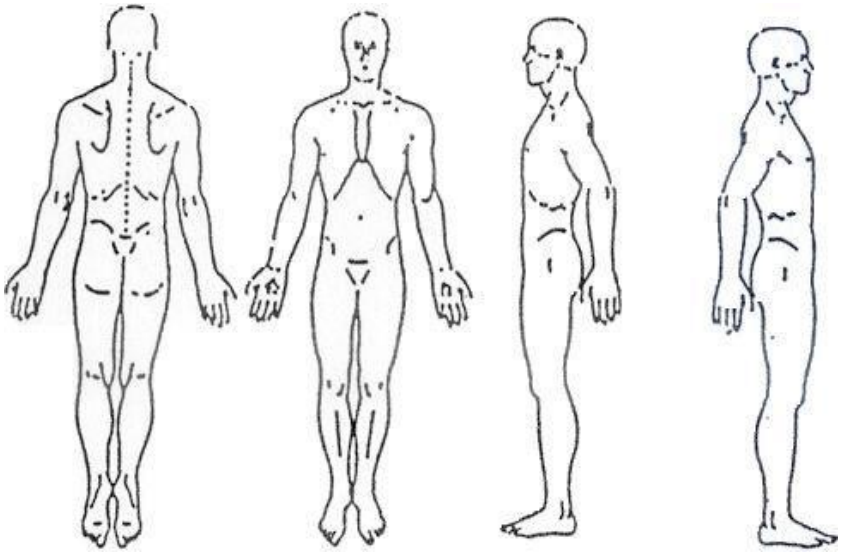
WORK _____ SLEEP _____ DAILY ROUTINE _____ SPORTS/EXERCISE _____ OTHER _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION

_____

_____

INDICATE PAINFUL OR DISTRESSED AREAS:
Please clearly mark any areas of pain (with XXX's), scars (with ------) and numbness (with OOO's).



PLEASE LIST OTHER DOCTORS YOU HAVE SEEN FOR THIS CONDITION

1. NAME/CITY _____
   TYPE OF DOCTOR _____ DATES SEEN _____
   DIAGNOSIS _____ TREATMENT _____
   RESULTS _____

2. NAME/CITY _____
   TYPE OF DOCTOR _____ DATES SEEN _____
   DIAGNOSIS _____ TREATMENT _____
   RESULTS _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD

1. TYPE: _____ DATE: _____ DOCTOR: _____
2. TYPE: _____ DATE: _____ DOCTOR: _____
3. TYPE: _____ DATE: _____ DOCTOR: _____

PLEASE LIST ANY ACCIDENTS AND/OR INJURIES: AUTO, WORK-RELATED, OR OTHER

1. TYPE: _____DATE: _____HOSPITALIZED: _____YES _____NO
2. TYPE: _____DATE: _____HOSPITALIZED: _____YES _____NO
3. TYPE: _____DATE: _____HOSPITALIZED: _____YES _____NO

PREVIOUS NATUROPATHIC/ACUPUNCTURE EXPERIENCE

HAVE YOU EVER CONSULTED WITH AN ND or LAC? _____ IF SO, WHO? _____

WERE YOU HAPPY WITH THE RESULTS OF YOUR VISIT(S)?

_____

WHAT THERAPIES WERE USED? (ACUPUNCTURE, CUPPING, MOXIBUSTION, LASER, NUTRITION CONSULTATION, HERBS, HOMEOPATHY…)

_____

HABITS

- ❑ **Alcohol**: Type_____ Amount_____
- ❑ **Smoking**: Packs daily_____ How long_____ Interested in stopping?_____
- ❑ **Caffeine**: Coffee, soda or tea, cups daily_____ Other _____
- ❑ **Sleep**: Difficulty falling asleep_____ Continuity disturbances_____ Hours of sleep per night _____ Daytime drowsiness_____ Other_____
- ❑ **Exercise routine**:_____ _____ _____ How often_____

MEDICINE / SUPPLEMENTS

PLEASE LIST ALL DRUGS YOU CURRENTLY TAKE OR HAVE TAKEN IN THE PAST 6 MONTHS

NAME _____ DOSAGE _____ FOR WHAT _____
NAME _____ DOSAGE _____ FOR WHAT _____
NAME _____ DOSAGE _____ FOR WHAT _____
NAME _____ DOSAGE _____ FOR WHAT _____

PLEASE LIST ALL NUTRITIONAL SUPPLEMENTS, VITAMINS, AND HOMEOPATHIC REMEDIES YOU PRESENTLY TAKE

NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____
NAME _____ FOR WHAT _____

DIET

DO YOU EAT BREAKFAST EVERY DAY? IF SO, WHAT DO YOU EAT? _____

HOW MANY MEALS PER DAY DO YOU EAT? _____

HOW MANY FRUIT SERVINGS DO YOU CONSUME PER DAY? _____ VEGETABLES? _____

DO YOU HAVE A SPECIAL DIET? IF SO, WHAT IS IT? _____

DO YOU HAVE ANY FOOD ALLERGIES? IF SO, WHAT ARE THEY? _____

HOW IS YOUR PHYSICAL HEALTH? (CIRCLE ONE) EXCELLENT GOOD FAIR POOR GETTING WORSE

MEDICAL HISTORY

Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General	☐ Poor appetite	☐ Poor sleep	☐ Fatigue	☐ Fevers	☐ Chills
☐ Night sweats	☐ Sweat easily	☐ Tremors	☐ Cravings	☐ Change in appetite	
☐ Poor balance	☐ Bleed or bruise easily	☐ Localized weakness	☐ Weight loss	☐ Weight gain	
☐ Peculiar tastes	☐ Desire hot food	☐ Desire cold food	☐ Strong thirst (cold or hot drinks)		
☐ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____					
Skin & hair	☐ Rashes	☐ Ulcerations	☐ Hives	☐ Itching	☐ Eczema
☐ Pimples	☐ Acne	☐ Dandruff	☐ Dry skin	☐ Recent moles	☐ Loss of hair
☐ Purpura	☐ Change in hair or skin texture		☐ Other?		
Musculoskeletal	☐ Joint disorders	☐ Muscle weakness	☐ Pain/soreness in the muscles		☐ Tremors
☐ Cold hands/feet	☐ Difficulty walking	☐ Swelling of hands/feet	☐ Spinal curvature	☐ Back pain	☐ Hernia
☐ Numbness	☐ Tingling	☐ Paralysis	☐ Neck tightness	☐ Neck pain	☐ Shoulder pain
☐ Hand/wrist pain	☐ Hip pain	☐ Knee pain	☐ Joint Sprain	☐ Other?	
Head, eyes, ears, nose, and throat		☐ Dizziness	☐ Concussions	☐ Migraines	☐ Glasses/lens
☐ Eye strain	☐ Eye pain	☐ Color blindness	☐ Night blindness	☐ Poor vision	☐ Cataracts
☐ Blurry vision	☐ Earaches	☐ Ringing in ears	☐ Poor hearing	☐ Spots in front of eyes	
☐ Sinus problems	☐ Nose bleeding	☐ Sore throat	☐ Grinding teeth	☐ Teeth problems	☐ Facial pain
☐ Jaw clicks	☐ Sores on lips/tongue	☐ Difficulty swallowing	☐ Other?		
Cardiovascular	☐ High blood pressure	☐ Low blood pressure	☐ Chest pain	☐ Palpitation	☐ Fainting
☐ Phlebitis	☐ Irregular heartbeat	☐ Rapid heartbeat	☐ Varicose veins	☐ Other?	
Respiratory	☐ Cough	☐ Coughing blood	☐ Wheezing	☐ Difficulty breathing	
☐ Bronchitis	☐ Pneumonia	☐ Chest pain	☐ Production of phlegm – What color? _____		
Gastrointestinal	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Gas
☐ Belching	☐ Black stools	☐ Blood in stools	☐ Indigestion	☐ Bad breath	☐ Rectal pain
☐ Hemorrhoids	☐ Abdominal pain/cramps	☐ Gallbladder problems	☐ Parasites	☐ Chronic laxative use	
Bowel movements:	Frequency _____	Color _____	Odor _____	Texture/ Form _____	
Neuro-psychological		☐ Loss of balance	☐ Lack of coordination	☐ Concussion	
☐ Depression	☐ Anxiety	☐ Stress	☐ Bad temper	☐ Bi-polar	
Genital-urinary	☐ Painful urination	☐ Frequent urination	☐ Blood in urine	☐ Urgency to urinate	
☐ Kidney stones	☐ Unable to hold urine	☐ Dribbling	☐ Pause of flow	☐ Frequent urinary tract infection	
☐ Genital pain	☐ Genital itching	☐Genital rashes	☐ STD	☐ Other?	

Female ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal/genital discharge

☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods

☐ Breast tenderness ☐ Breast Lumps ☐ Fertility Problems ☐ Hot flashes ☐ Moodiness related to periods

_____ Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions

_____ Premature births _____ C-section _____ Difficult delivery

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Do you practice birth control ? ☐ Yes ☐ No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male ☐ Prostate problems ☐ Discharge ☐ Erectile dysfunction ☐ Ejaculation problems

☐ Frequent seminal emission ☐ Fertility problems ☐ Painful/swollen testicles ☐ Other

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:				**HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:**	
RELATIONSHIP	*AGE IF LIVING*	*AGE AT DEATH*	*STATE OF HEALTH OR CAUSE OF DEATH*	*ILLNESS*	*FAMILY MEMBER*
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____ _____ _____	_____ _____ _____	_____ _____ _____	BLOOD DISEASE GLAUCOMA EPILEPSY	_____ _____ _____
SPOUSE				ARTHRITIS	
				BACK PROBLEMS	
CHILDREN	_____ _____ _____	_____ _____ _____	_____ _____ _____	HEART DISEASE GOUT HIGH BLOOD PRESSURE	_____ _____ _____

WHAT DO YOU HOPE TO ACCOMPLISH FROM OUR TIME TOGETHER? HOW LONG DO YOU EXPECT IT TO TAKE TO ACCOMPLISH THAT GOAL?

_____

_____

CONSENT FOR CONSULT AND TREATMENT

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Doctor's office of any changes in my medical status. I understand acupuncture treatment to involve the use of needles, acupressure, cupping, lasers and electrical stimulation, etc. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

Signature_____Date_____

(Parent or Guardian, if under 18)