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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 \_\_\_\_\_

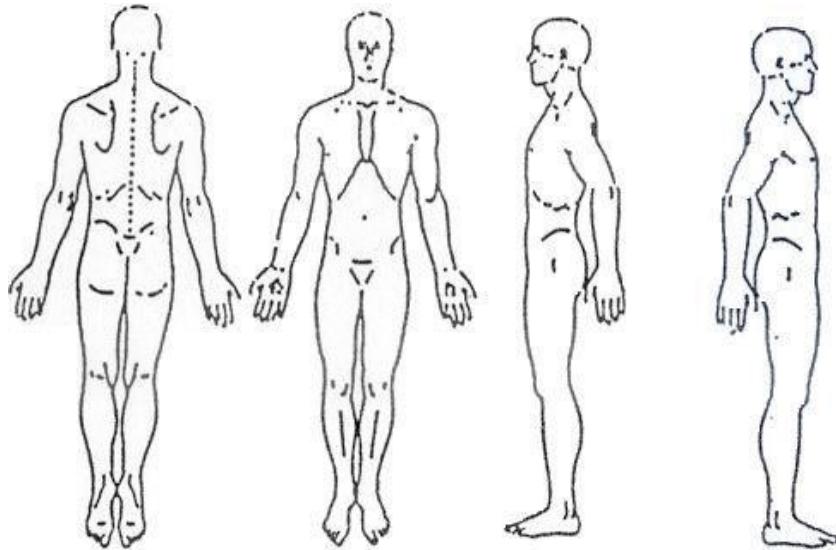
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION

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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.

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

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**Male**   ☐ Prostate problems   ☐ Discharge   ☐ Erectile dysfunction   ☐ Ejaculation problems  
☐ Frequent seminal emission   ☐ Fertility problems   ☐ Painful/swollen testicles   ☐ Other

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## **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)