MEDICAL HISTORY FOR TCM

Integrative Acupuncture
The Healing Alternative

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully.
All of your answers will be held absolutely confidential

Patient Signature: ____

Name: (First, Last) _______________________________________ **Date:** ___________

Street: __________________________**City:** __________________ **Zip Code:** _______

Home Phone: _______________ **Work Phone:** ___________ **Cell:** ____________

Email: ________________________

Date of Birth: ______________ **Age:** _______ **Height:** _________ **Weight:** ______

Marital Status: _____________ **Occupation:** ________________________________

Family Physician: _____________________________ **Referred by:** ____________________

Emergency Contact Info: Name _______________________ **Tel:** ___________________
Relationship to Patient: ______________________________

Have you been treated by acupuncture or Oriental Medicine before? Yes No

Main problem you would like us to help with: ______________________________________

Have you been given a diagnosis for this problem? Yes___ No___
If so, what and by whom? ____

How long ago did this problem begin? Please be specific. ___________________________

To what extent does this problem interfere with your daily activities, such as work, sleep and sex?
____

What kinds of treatment(s) have you tried? Circle all that apply.

Chiropractor Physical Therapy Cranial Sacral Massage Herbs Reiki

Homeopathy Naturopath Other (explain) _______________________________________

PAST MEDICAL HISTORY (Circle all that apply)

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Asthma
Rheumatic Fever Thyroid Disease Seizures Stroke Venereal Disease

Autoimmune: Celiac Fibromyalgia Eczema Psoriasis Lupus
Lyme Disease Multiple Sclerosis Other ____________________
Other (list) ____

Allergies (list all – chemicals, foods, drugs): ___________________________________

Surgeries: ____

Significant Trauma (auto accidents, falls, etc.): _______________________________

GENETIC HISTORY (circle all that apply)

Muscular Dystrophy Cystic Fibrosis Hemophilia Chromosomal Disorder

Factor V Other____________________

Name________________________________ Date:______________

FAMILY MEDICAL HISTORY (circle all that apply)

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease

Rheumatic Fever Thyroid Disease Seizures Stroke Asthma

Venereal Disease Other (list) ____

MEDICATIONS: List all medicines taken within the last two months (vitamins, drugs, herbs, etc.):

Are there areas of your life that are stressful? Circle all that apply:
Home Work Family Psychological Stress Physical Stress

Do you exercise regularly? Yes No
If yes, what type and frequency____

Do you smoke? No Yes If yes, how many cigarettes/cigars per day? ____________

Please describe drug use for non-medical reasons: _________________________________

How many times per week do you drink alcohol? ____ Caffeinated beverages? ____

NUTRITION

How many times per week do you eat/drink the following:

Red meat ____ Poultry products _____ Fish/Shellfish _____ Dairy Products ____

Whole grain foods _____ Fruits/Vegetables _____

Eat out in a restaurant or take food out? ______

Have you ever been on a special or restricted diet? (vegetarian, vegan, medical related, other)
Yes No If yes, describe ______________________________

How many 8 oz. glasses of water do you drink per day? ______

Please check is you have had any of the following in the last three months:

GENERAL			
❑Fevers	❑Night sweats	❑Weight loss	❑ Weight gain
❑Chills	❑Fatigue	❑Poor sleep	❑Bleed/bruise easy
❑Cravings	❑Change in appetite	❑Peculiar tastes or smells	
❑Sudden energy drop. What time of day? _______			
❑Strong thirst for ❑Hot drinks ❑Cold drinks			

SKIN AND HAIR			
❑Rashes	❑Ulcerations	❑Hives	❑Itching
❑Eczema	❑Pimples	❑Dandruff	❑Loss of Hair
❑Recent moles	❑Psoriasis	❑Dermatitis	❑Acne
❑Change in hair or skin texture			
❑Any other skin or hair problems?			

HEAD, EYES, EARS, NOSE, THROAT			
❑Dizziness	❑Concussions	❑Migraines	❑Glasses
❑Eye strain	❑Eye pain	❑Poor vision	❑Night blindness
❑Color blindness	❑Cataracts	❑Blurry vision	❑Earaches
❑Ringing in ears	❑Spots in front of eyes	❑Poor hearing	❑Sinus problems
❑Nose bleeds	❑Recurrent sore throats	❑Grinding teeth	❑ Sores on lips and tongue
❑Facial pain	❑Clenching jaw	❑Teeth problems	❑Jaw clicks
❑Headaches, where and when		❑Any other head or neck problem? Describe.	

Name___________________________________ Date:______________

CARDIOVASCULAR			
❑High blood pressure	❑Low blood pressure	❑Chest pain	❑Fainting
❑Irregular heart beat	❑Difficulty breathing	❑Blood clots	❑Phlebitis
❑Cold hands/feet	❑Swelling of hands	❑Swelling of feet	❑Palpitations
❑Palpitations at rest		❑Varicose or spider veins	
❑Any other heart or blood vessel problems?			

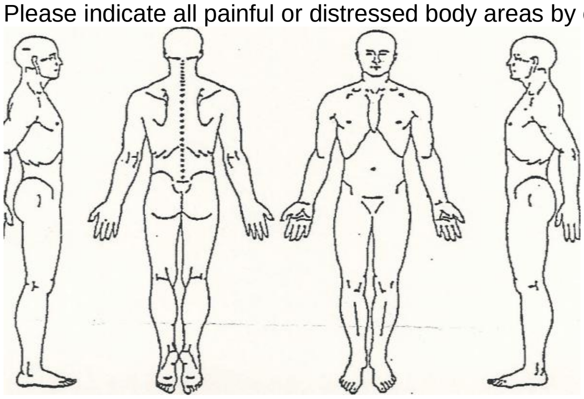
RESPIRATORY			
❑Cough	❑Coughing blood	❑Asthma	❑Bronchitis
❑Pneumonia	❑Chest tightness	❑Pain with deep breath	
❑Difficulty breathing lying down		❑Phlegm production. Color?______	

GENITO-URINARY			
❑Frequent urination	❑Blood in urine	❑Painful urination	❑ Decreased flow
❑Urgency to urinate	❑Unable to hold urine	❑Kidney stones	❑ Sores on genitals
❑Wake at night to urinate. How many times per night? ____			
What color is the urine? Yellow Pale Yellow Cloudy Red tinged Dark Yellow No color			
❑Any other problems with your genital or urinary systems?			

GASTROINTESTINAL			
❑Nausea	❑Vomiting	❑Black stool	❑Constipation
❑Gas	❑Belching	❑Rectal pain	❑Blood in stool
❑Indigestion	❑Bad breath	❑Bloating/edema	❑Chronic laxative use
❑Bleeding gums	❑Hernia	❑Poor appetite	❑ IBS/Crohn's disease
❑Colitis	❑Excessive appetite	❑Diarrhea	❑ Abdominal pain/cramps
❑Slow digestion	❑Acid reflux/GERD	❑Hemorrhoids	❑Loose stool more than 2x day
❑Any other problem with stomach or intestine?			

MUSCULOSKELETAL			
❑Neck pain	❑Rotator cuff	❑ Knee pain	❑Foot/ankle pain
❑Muscle pain	❑ Tendonitis	❑Muscle weakness	❑Shoulder pain
❑Hip pain	❑Sciatica	❑Bursitis	❑Hand/wrist pain
❑Carpel tunnel	❑Sprains/strains		
❑Back pain ❑Low ❑Middle ❑Upper			
❑Soreness/weakness of the lower body (back, hip, knee, ankle, foot)			

Please indicate all painful or distressed body areas by circling the specific area:



Decribe pain:

❑ Sharp ❑ Burning ❑ Aching

❑ Fixed ❑ Numbness

❑ Other_______________

NEUROLOGICAL & PSYCHOLOGICAL			
❑Seizures	❑Dizziness	❑Loss of balance	❑Concussion
❑Poor memory	❑Areas of numbness	❑Poor coordination	❑Numbness/tingling in fingers or toes
❑Bad temper	❑Anxiety	❑Depression	❑Nervousness
❑Easily susceptible to stress		❑ADD/AHD	❑Manic depression
❑Have you ever treated for emotional problems? Yes ❑ No ❑			
❑Have you ever considered or attempted suicide? Yes ❑ No❑			
Any other neurological or psychological problems?			

Name_________________________________ Date:_____________

Women Only

REPRODUCTIVE & GYNECOLOGIC			
Are you pregnant? Yes No			
Is it possible that you are pregnant? Yes No			
Number of pregnancies: ______		Live births: _____	Miscarriages: ____
Age at first menses: ______		Premature births: __	Abortions: ______
Date your last period began: ____________			
Duration of menses (number of days flowing): ____			Last PAP: ____
How many days long is your menstrual cycle: ____			
❑Irregular periods	❑Painful periods	❑Endometriosis	❑Breast lumps
❑Vaginal sores	❑Vaginal discharge	❑Clots	❑Fibrocystic breast tissue
❑Uterine fibroids	❑Polycystic Ovary Disease/PCOS		❑Vaginal dryness
Color of blood: Dark Red Bright Red Pale Red Pink Brown Black			
Describe menstrual Flow: Heavy____Moderate____Light____			

Do you practice birth control? Yes ____ How long? ____

❑ None ❑Spermicides ❑ IUD

❑Barriers ❑ Birth control pills name_______________

Are you in menopause? Yes___ No___ How long? __________

Have you had a Hysterectomy? Yes___ No___ Ovaries removed? Yes___ No___

Post-menopausal Bleeding? Yes___ No___

Do you suffer from:

Cramping

❑Severe ❑Moderate

❑Mild ❑Before Period

❑During Period ❑After Period

Clotting

❑ Bright in color ❑Dark in color

❑ Bleeding between periods ❑ Mastitits ❑ Infertility

❑Pelvic Imflam. Disease ❑ Breast Cysts ❑Hot Flashes

❑ Endometriosis ❑ Ovarian Cysts ❑Yeast Infection/Vaginitis /Other Discharge

Premenstrual Syndrome: ❑Fluid Retention ❑Fluctuating Emotions ❑Tenderness in breasts

Men Only

REPRODUCTIVE

❑ Reproductive Surgery	❑Premature Ejaculation	❑Prostate Problems
❑Impotence	❑Mumps	❑Infertility
❑Discharge from Penis	❑STDs	❑Low Sex Drive
❑Testicular Pain or Lump	❑Weak Erection	❑Testicular Trauma

COMMENTS:
Please tell us briefly of any other problems you would like to discuss.

____
____
____

PAIN/DISCOMFORT SCALE
Please circle on the scale of 1 to 10 below the level of pain/discomfort associated with your main complaint:

1 2 3 4 5 6 7 8 9 10
Least pain Severe pain

If your main complaint does not include pain or discomfort, please indicate the severity of your complaint.

1 2 3 4 5 6 7 8 9 10
Not a problem Very severe