ACUPUNCTURE CENTER
CHICAGO

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Important : Complete this document as thoroughly as possible.

Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential

I. General Patient Information

Name:_____ Gender: ☐ M ☐ F Height:_____ ' _____" Weight: _____ lbs

phone: (____)_____ Email: _____@_____

Address: _____City, State, Zip Code: _____ _____

Social Security Number:____ -____- _____ Date of Birth: _____/_____/_____ Age:_____ Guardian (if under 18): _____

Occupation:_____ Employer: _____ Work phone: _____

Emergency contact: _____ Emergency phone : _____ Relationship: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:	How long	How often	Pain Level from 0-10 10=worst
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

How do these conditions impair your daily activities? _____

II. Patient Medical History

Are you currently taking any physician prescribed medications? If yes, please list below.

Medication	Prescribed for:	Medication	Prescribed for:

How was your childhood health? _____

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Prostate ☐ HIV/STD ☐ Mammography

☐ Cholesterol ☐ Blood (which?)_____ ☐ Pap smear ☐ Other:_____

Test Results and Date: _____

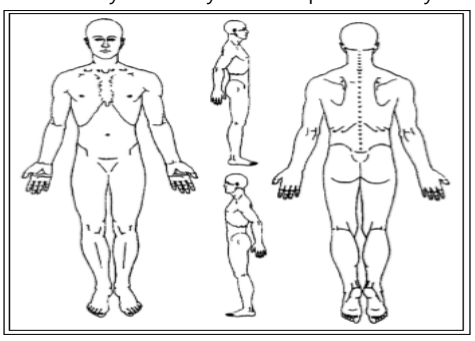
Check any you have had in the past:

☐ Diabetes	☐ Bleeding tendency	☐ Rheumatic Fever	☐ Measles	☐ Vein condition
☐ Thyroid disorder	☐ HIV	☐ Tuberculosis	☐ Epilepsy	☐ Gonorrhea
☐ Mumps	☐ Paralysis	☐ Syphilis	☐ High blood pressure	☐ Nervous disorder
☐ Meningitis	☐ Glaucoma	☐ Mononucleosis	☐ CVA (stroke)	☐ Multiple Sclerosis
☐ Seizures	☐ Pneumonia	☐ Migraines	☐ Jaundice	
☐ Allergies	☐ Polio	☐ Heart Disease	☐ Chicken pox	
☐ Asthma	☐ Cancer	☐ Emphysema	☐ High fever	

Surgeries: _____

III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas scars are):



Is the pain?

☐ Sharp ☐ Burning ☐ Aching ☐ Cramping ☐ Dull

☐ Moving ☐ Fixed ☐ Other: _____

Do the following lessen the pain?

☐ Pressure ☐ Exercise ☐ Cold ☐ Heat ☐ Other: _____

Do the following worsen the pain?

☐ Pressure ☐ Exercise ☐ Cold ☐ Heat ☐ Other: _____

Do you internally feel warm or cold most of the time?

☐ Cold ☐ Warm

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's functions in Traditional Chinese Medicine):

Spleen/ Stomach Meridian / Organ Network

- ☐ Low appetite
- ☐ Hemorrhoids
- ☐ Abdominal bloating
- ☐ Ulcer (diagnosed)
- ☐ Acid reflex / heartburn
- ☐ Over-thinking
- ☐ Belching
- ☐ Cancer
- ☐ Mouth sores
- ☐ Worry
- ☐ Hiccups
- ☐ Irritable bowel
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Bad breath
- ☐ Stomach gurgling noise
- ☐ Excessive appetite
- ☐ Stomach pain
- ☐ Chronic disease
- ☐ Aching heavy limbs
- ☐ Fatigue after eating
- ☐ Nausea
- ☐ Loose stools
- ☐ Poor memory
- ☐ Easily bruised
- ☐ Vomiting
- ☐ Difficulty focusing
- ☐ Burning after eating
- ☐ Passing gas
- ☐ Gastritis
- ☐ Diabetes
- ☐ Prolapsed organs(diagnosed)
- ☐ Headaches
- ☐ Weak muscles
- ☐ Indigestion

Heart/ Small Intestine Meridian/ Organ Network

- ☐ Mental confusion
- ☐ Restlessness
- ☐ Sores on tip of tongue
- ☐ Drink coffee #___cup/day
- ☐ Abdominal pain
- ☐ Phobias
- ☐ Muscle tone
- ☐ Inflammatory conditions
- ☐ Insomnia
- ☐ Tongue/speech problem
- ☐ Urinary problem
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Dizziness
- ☐ Wake un-refreshed
- ☐ Dream disturbed sleep
- ☐ Hot flashes
- ☐ Spontaneous sweating
- ☐ Nightmares
- ☐ Cold limbs
- ☐ Lupus
- ☐ Poor circulation
- ☐ Psychosis
- ☐ Cardiac pain
- ☐ Chest to shoulder pain
- ☐ Vertigo
- ☐ Difficulty falling asleep
- ☐ Pain down the arms
- ☐ Anemia
- ☐ Disturbed thinking
- ☐ Heart problem
- ☐ Hot painful joint
- ☐ Rheumatoid arthritis
- ☐ Sleep problem
- ☐ Epilepsy
- ☐ Anxiety
- ☐ Hearing problem
- ☐ Upper back pain
- ☐ Bitter taste in mouth

Liver/ Gall Bladder Meridian/ Organ Network

- ☐ Chest pain
- ☐ Muscle twitching
- ☐ Pain in ribs
- ☐ Tinnitus
- ☐ Tightness in Chest
- ☐ Hiccups
- ☐ Tendonitis
- ☐ Migraines
- ☐ Anger easily
- ☐ Gall stones history
- ☐ Migratory pain
- ☐ Insomnia
- ☐ Frustration
- ☐ PMS symptoms
- ☐ Belching
- ☐ Drink alcohol
- ☐ Depression
- ☐ Substance abuse
- ☐ Chronic fatigue
- ☐ Sighing
- ☐ Irritability
- ☐ Distention/bloating
- ☐ Sour regurgitation
- ☐ Tremors
- ☐ Skin rashes
- ☐ Irritable bowel
- ☐ Seizures
- ☐ Muscle cramping
- ☐ Tingling sensation
- ☐ Vertigo
- ☐ Fibromyalgia
- ☐ Numbness
- ☐ Flushed face
- ☐ Convulsions
- ☐ Muscle spasms
- ☐ Nausea
- ☐ Floaters
- ☐ Brittle/coarse nails or hair
- ☐ Parkinson's disease
- ☐ Headache at temples
- ☐ Sensitivity to greasy foods
- ☐ Repetitive strain disorder

(please List) : _____

_____

Kidney/ Urinary Bladder Meridian/Organ Network

- ☐ Frequent cavities
- ☐ Memory problems
- ☐ Easily startled
- ☐ Sciatica
- ☐ Spinal column diseases
- ☐ Decreased will power
- ☐ Osteoarthritis
- ☐ Afternoon flushes
- ☐ Lack of perspiration
- ☐ Cold sensation in knees
- ☐ Heat in chest
- ☐ Other dental problems
- ☐ Excessive hair loss
- ☐ Cold body temperature
- ☐ Kidney stones
- ☐ Frequent night urination
- ☐ Cold hands or feet
- ☐ Multiple Sclerosis
- ☐ Heat in hands or feet
- ☐ Lower back pain
- ☐ Fear
- ☐ Premature gray hair
- ☐ Hot Flashes
- ☐ Infertility
- ☐ Hot body temperatures
- ☐ Perspire easily
- ☐ Easily broken bones
- ☐ Night sweats
- ☐ Excessive thirst
- ☐ Cerebral palsy
- ☐ Depression
- ☐ Lack of bladder control
- ☐ Fatigue/ lethargy
- ☐ Muscular Dystrophy
- ☐ Sterility
- ☐ Unusual urination out-put

Lung Function/ Large Intestine Meridian /Organ Network

- ☐ Difficulty breathing
- ☐ Loose stools
- ☐ Dry skin
- ☐ Excess phlegm
- ☐ Tuberculosis
- ☐ Sweating problems
- ☐ Smoke (#___ per day)
- ☐ Sadness
- ☐ Difficulty concentrating
- ☐ Frequent colds/flu
- ☐ Psoriasis
- ☐ Sinusitis
- ☐ Shortness of breath
- ☐ Cough
- ☐ Rapid, quick thinking
- ☐ Slow healing skin
- ☐ Pulmonary diseases
- ☐ Nasal problems
- ☐ Constipation
- ☐ Melancholy
- ☐ Asthma
- ☐ Breast fed
- ☐ Mucus in stool
- ☐ Diarrhea
- ☐ Chest congestion
- ☐ Wheezing
- ☐ Emphysema
- ☐ Bottle fed

☐ Sensitivity to: ☐ smells ☐ noise ☐ clothing ☐ energy ☐ other (list) : _____

For Women:

Regular menstrual cycle? ☐ Y ☐ N Pregnant? ☐ Y ☐ N

Last period : _____/_____/_____

Number of children: _____ Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause (if applicable) : _____

Average number of days of flow: _____ Average number of days of entire cycle: _____

☐ Vaginal discharge ☐ Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

☐ nausea ☐ breast swelling ☐ migraines ☐ irritability

☐ vomiting ☐ food cravings ☐ breast tenderness ☐ anxiety

☐ water retention ☐ headaches ☐ depression ☐ other emotions: _____

☐ dull pain, where? _____ ☐ sharp pain, where? _____

Please fill in the following menstrual chart:

	before	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Color : Normal, Bright Red, Pale, Brown, Rust , Dark, Pruple, other							
Amount of flow : Normal, Heavy, Light							
Pain/ Cramps : location, Dull, Sharp, Other							
Clots : Large, Small, Black, Purple, Red, Other							
Vomiting (check if yes)							
Nausea (Check if yes)							
Other							

For Men:

☐ Swollen testes ☐ Testicular pain ☐ Impotence ☐ Premature ejaculation

☐ Feeling of coldness or numbness in external genitalia ☐ Other : _____

Patient Signature : _____ Date : _____