Acu Equilibrium JC, LLC

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Name _____ Date _____

Address _____ City _____ State ____ Zip _____

Telephone# _____ Social Security# _____ Age _____

Email address _____Date of Birth _____ Sex [ ]M [ ] F

[ ]Married [ ]Single [ ]Divorced [ ]Widow/Widower

Height _____ Weight _____ Occupation _____

How did you find out about our acupuncture services? _____

Is this your first acupuncture experience? [ ]Yes [ ]No

Have you had Chinese herbs? [ ]Yes [ ]No

Name of family physician _____ Address _____

Date of last medical examination _____

Emergency Contact _____ Relationship to Patient _____

Emergency Contact Phone number _____

Insurance Information

Insurance Coverage _____Policy # or ID # _____

Health History

I. Goals: What would you most like to achieve through your treatment with acupuncture?

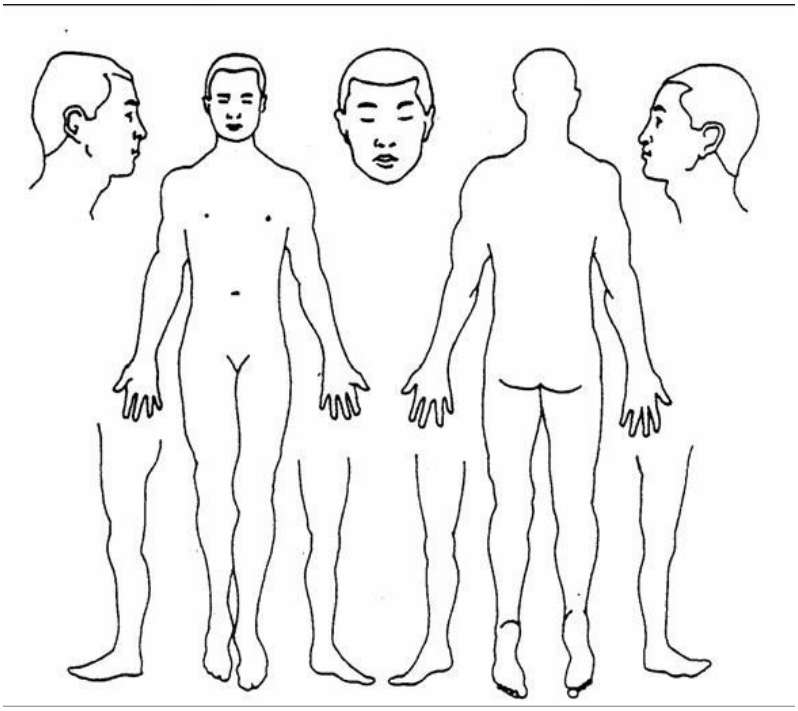
1. _____
2. _____
3. _____
4. _____
5. _____

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

1. _____
2. _____
3. _____
4. _____

Have you received any treatment for your symptoms? [ ] Yes [ ] No
If yes, please list the treatments _____
_____

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? Y / N

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

For Women:
Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

Indicate number of occurrences:
Live Births _____ Pregnancies_____ Miscarriages _____ Abortions _____

Age: First period _____ Menopause (if applicable) _____

Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____
Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? _____

Is your menses cycle regular? [ ] Yes [ ] No
Average number of days of flow _____ Average number of days between flow _____
The flow is: [ ] Normal [ ] Heavy [ ] Light
The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

Do you have the following menstruation related signs/symptoms?
[ ] Difficulty with Orgasm [ ] Cramps [ ] PMS [ ] Heavy Vaginal discharge between periods
[ ] Pain with Intercourse [ ] Nausea [ ] Bleeding between Periods
[ ] Blood Clots [ ] Breast Distention [ ] Vaginal Discharge

For Men:
Do you have any bothersome urinary symptoms? [ ] Yes [ ] No
Describe:_____

Check all that apply:
[ ] Erectile dysfunction [ ] Difficulty with orgasm [ ] Pain or swelling of the testicles
[ ] Frequent need to urinate at night [ ] Impotence/erectile dysfunction [ ] Premature ejaculation
[ ] Feeling of coldness or numbness in genitalia [ ] Pain/Subtly of testicles

Do you get up at night to urinate? [ ] Yes [ ] No
How often? _____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?
_____

Have you sought medical intervention for these problems?
If so, what and when? _____ _____

III. Medical History (Please check all that apply)

	Date Diagnosed		Date Diagnosed
Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	High Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

Were you in a motor vehicle accident? [ ] Yes [ ] No (If no, skip to next section)
If yes, were you the driver/passenger/pedestrian/biker? _____
Were you or was your car struck from the front/left/right/rear-end? _____
Were you taken or did you go to the Emergency Room? [ ] Yes [ ] No If so, which hospital? _____

IV. Surgical History
_____ Date _____
_____ Date _____
_____ Date _____

V. Family History
Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications / Supplements
Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over counter medicines you take on a regular basis, along with dosages and brands if known)
_____
_____
_____
_____

Allergies (to medications, chemicals or foods):
_____

VII. Nutrition
Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet? (ie Vegetarian, Vegan, Low Carb etc.)_____
What do you eat on a "typical" day? _____
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Foods you tend to crave: _____
Foods you dislike: _____

VIII. Social History
How much per day do you use of the following?
Coffee, tea, soft drinks: _____
Alcohol: _____
Cigarettes, cigars, other tobacco: _____
Other drugs: _____

Have you ever had a problem with alcohol or alcoholism? [ ] Yes [ ] No
Have you ever had a problem with dependency on other drugs? [ ] Yes [ ] No
If yes, which and when?
_____

Do you have a known history of any exposure to toxic substances? [ ] Yes [ ] No
If so, please list which and when you first noticed symptoms?
_____

In the past year, how many days have been significantly affected by your health? _____
How many days did you feel generally poor? _____
How many times were you in the hospital? _____

Please describe your current exercise regimen:
Hours per week: _____ Activities: _____ [ ] No Exercise

How many hours of sleep do you usually get per night during the week? _____
Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

Who would you describe as your source of primary social support? (Relationship to you)
_____

IX. Other Information
Please list and briefly describe the most significant events in your life:
1. _____
2. _____
3. _____

Have you been treated for emotional issues? [ ] Yes [ ] No
Have you ever considered or attempted suicide? [ ] Yes [ ] No
Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:
_____
_____
_____

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _____

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HEAD & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _____

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _____

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: _____

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: _____

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: _____

MALE

Past	Current	Condition
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: _____

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: _____

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: _____

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: _____

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain