FOR EXAM & FIRST TREATMENT APPOINTMENT

1. You should eat food within 6 hours of receiving your treatment. If you have not, a light snack is recommended. It is important that you do not eat a heavy meal or drink alcohol right before your treatment.

2. Depending on the nature of the complaint, needles may be retained for various lengths of time, and additional modalities may need to be used, thus resulting in varying treatment times.

3. It is not always necessary to disrobe. Depending on where the needles are placed, specific article of clothing may need to be removed. It is advisable to wear undergarments since it is not always possible to cover the body completely.

4. For accurate diagnosis, it is important to examine your tongue. If possible, do not brush your tongue the day or your exam and treatment. Additionally, try to avoid coffee, tea, or hard candies within 2 hours of treatment as these will falsely discolor the tongue.

5. Only pre-sterilized, disposable acupuncture needles are used. Needles are not reused.

FOR CONSULTATION APPOINTMENT

1. Please complete the enclosed medical history forms, and bring them with you to your first appointment.

2. We require a minimum 24 hour notice of cancellation if you are unable to keep your appointment. The initial consultation is a service we provide free of charge to find out if we are able to help you with your current health problems, without cost of obligation. We set aside 2 hours for this appointment and would normally cost $140. There is no treatment at this appointment. To schedule your exam and treatment to follow, please call our office.
Important: Complete this document as thoroughly as possible. Some of the question that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

GENERAL PATIENT INFORMATION
Date: _______________  Name: (Mr. - Mrs. - Ms.) ________________________________
Address: ___________________________________  City, State, Zip: ________________________________
Home Phone: _______________  Work Phone: _______________  Cell Phone: _______________
Age: ______  Date of Birth: _______________  Email: ________________________________
Legal Guardian: (if under 18 years of age) __________________________________________
Emergency Contact: (name and phone number) _______________________________________
Gender: ___ M ___ F  Height: _____ ' _____ "  Weight: ____ lbs  SSN: __________________________
Driver’s License Number: __________________________  Occupation: __________________________
Employer: __________________________  How did you hear about us? __________________________

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE
1. __________________________________________  2. __________________________________________
3. __________________________________________  4. __________________________________________
5. __________________________________________  6. __________________________________________
How do these conditions impair your daily activities? __________________________________________
Important: Complete this document as thoroughly as possible. Some of the question that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

PATIENT MEDICAL HISTORY
How was your childhood health? __________________________________________________________

Hospital visits/stays: ___________________________________________________________________

Recent Tests: (please indicate test results and date below)
☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?) ☐ HIV/STD ☐ Pap Smear ☐ Mammography ☐ Other

Test results and date: ___________________________________________________________________

Check any that you have had in the past:
☐ Diabetes ☐ Allergies ☐ Glaucoma ☐ Rheumatic Fever
☐ Heart Disease ☐ CVA (stroke) ☐ Vein Condition ☐ Thyroid Disorder
☐ Asthma ☐ Pneumonia ☐ Tuberculosis ☐ Emphysema
☐ Jaundice ☐ Gonorrhea ☐ Mumps ☐ Bleeding Tendency
☐ Syphilis ☐ Measles ☐ Chicken Pox ☐ Nervous Disorder
☐ Meningitis ☐ HIV ☐ Polio ☐ Mononucleosis
☐ Epilepsy ☐ High Fever ☐ Hepatitis ☐ Multiple Sclerosis
☐ Paralysis ☐ Cancer ☐ Migraines ☐ High Blood Pressure
☐ Other Lung Illness ☐ Other Liver Illness ☐ Other Heart Illness ☐ Other Kidney Illness
☐ Other ________________________________________________________________

Immunizations: _______________________________________________________________________

Surgeries: ___________________________________________________________________________
**HEALTH HISTORY QUESTIONNAIRE**
INFORMATION FOR YOUR ACUPUNCTURIST

**PATIENT PROFILE**
Please clearly mark any areas of pain and any scares (please indicate which of the areas are scars)

Is the pain:

- [ ] Sharp
- [ ] Cramping
- [ ] Fixed
- [ ] Burning
- [ ] Dull
- [ ] Moving
- [ ] Aching
- [ ] Other: ________________

Do the following improve the pain?

- [ ] Pressure
- [ ] Exercise
- [ ] Cold
- [ ] Heat
- [ ] Other: ________________

Do the following worsen the pain?

- [ ] Pressure
- [ ] Cold
- [ ] Heat
- [ ] Other: ________________

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 function):

**OVERALL TEMPERATURE** *(Kidney Function)*

- [ ] Sweaty feet
- [ ] Hot body temperature (sensation)
- [ ] Cold body temperature (sensation)
- [ ] Afternoon flushes
- [ ] Night sweats
- [ ] Heat in the hands, feet, and chest
- [ ] Hot flashes any time of the day
- [ ] Thirsty
- [ ] Perspire easily
- [ ] Lack of perspiration
- [ ] Take water to bed
- [ ] Cold hands and feet
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 function):

**OVERALL ENERGY** (Lung, Kidney function)

- [ ] Shortness of breath
- [ ] Difficulty keeping eyes open in the daytime
- [ ] Low energy
- [ ] General weakness
- [ ] Feel worse after exercise
- [ ] Easily catch colds

**OVERALL BLOOD** (Liver, Spleen, Heart function)

- [ ] Dizziness
- [ ] See floating black spots

**HEART FUNCTION**

- [ ] Palpitations
- [ ] Sores on the tip of the tongue
- [ ] Mental confusion
- [ ] Frequent dreams
- [ ] Anxiety
- [ ] Restlessness
- [ ] Chest pain traveling to shoulder
- [ ] Wake unrefreshed
- [ ] Drink coffee (# of cups per week:_______)

**LUNG FUNCTION**

- [ ] Nasal Discharge (Color: ________________)
- [ ] Coughs
- [ ] Dry throat
- [ ] Sneezing
- [ ] Allergies (To what? ________________)
- [ ] Nose Bleeds
- [ ] Dry nose
- [ ] Achy feeling
- [ ] Headache (Location: ________________)
- [ ] Sinus Congestion
- [ ] Dry skin
- [ ] Stiff neck
- [ ] Smoke cigarettes (# of cigarettes a day: ___)
- [ ] Dry Mouth
- [ ] Sore throat
- [ ] Stiff shoulders
- [ ] Alternating fever and chills
- [ ] Sadness
- [ ] Difficulty breathing
- [ ] Melancholy
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 function):

**SPLLEEN FUNCTION**
- Low appetite
- Abdominal gas
- Easily bruised
- Worry
- Abrupt weight gain
- Gurgling noise in the stomach
- Hemorrhoids
- Over-thinking
- Abrupt weight loss
- Fatigue after eating
- Pensive
- Abdominal bloating
- Prolapsed organs (previously diagnosed, which organ? __________)

**SPLLEEN, STOMACH, LARGE INTESTINE, SMALL INTESTINE FUNCTION**
- Loose
- Incomplete
- Blood in stools
- Undigested food in stools
- Constipated
- Diarrhea
- Mucous in stools

**DAMPNESS TRAPPED IN THE BODY**
- Mental heaviness
- Swollen hands
- Chest congestion
- Mental sluggishness
- Swollen feet
- Nausea
- Mental fogginess
- Swollen joints
- Snoring
- General sensation of heaviness in the body
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 function):

**STOMACH FUNCTION**

- Large appetite  
- Heartburn  
- Belching  
- Bad breath  
- Acid regurgitation  
- Hiccups  
- Mouth (canker) sores  
- Ulcer (diagnosed)  
- Stomach pain  
- Burning sensation after eating  
- Bleeding, swollen or painful gums  
- Vomiting

**LIVER, GALL BLADDER FUNCTION**

- Alternating diarrhea and constipation  
- Frustration  
- Convulsions  
- Headache at the top of the head  
- Depression  
- Lump in the throat  
- Tight sensation in the chest  
- Irritability  
- Neck tension  
- Bitter taste in the mouth  
- Skin rashes  
- Drink alcohol  
- High-pitched ringing in the ears  
- Chest pain  
- Shoulder tension  
- Gall stones (history or current)  
- Anger easily  
- Muscle twitching  
- Tendon, ligament or joint problems  
- Limited Range-of-Motion, neck  
- Pain under the ribcage  
- Seizures  
- Limited Range-of-Motion, shoulder  
- Tingling sensation  
- Numbness  
- Vertigo  
- Sexually transmitted disease (Which?__________________________________________)
- Recreational drugs (Which? _________________, How much per week? ________)
- Frequently unable to adapt to stress (What causes the stress?____________________)
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 function):

### EYES (Liver function)
- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

### KIDNEY, URINARY BLADDER FUNCTION
- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing the ears
- Kidney stones
- Bladder infections
- Wake during the night twice to urinate
- Lack of bladder control
- Fear
- Easily startled

### URINATION
- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong color
- Burning
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

### LIBIDO
- Normal
- High
- Low
WOMEN ONLY

Regular menstrual cycle?  Y  N
Number of children: _______ Age of first menstruation: _______

Average number of days of flow: __________ Vaginal discharge?  Y  N  Pregnant?  Y  N

Number of pregnancies: _____________________ Age of menopause (if applicable): ___________________

Average number of days of entire cycle: _____________________ Bleeding between periods?  Y  N

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

- Nausea
- Food cravings
- Depression
- Dull pain, Where? ___________________
- Vomiting
- Headaches
- Irritability
- Sharp pain, Where? ________________
- Water retention
- Migraines
- Anxiety
- Other emotions
- Breast swelling
- Breast tenderness
- Other emotions

Please fill out the following menstrual chart

<table>
<thead>
<tr>
<th>Day</th>
<th>Day</th>
<th>Day</th>
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<th>Day</th>
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Color (normal, bright red, pale, brown, rust, dark, purple, 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
HEALTH HISTORY QUESTIONNAIRE
INFORMATION FOR YOUR ACUPUNCTURIST

MEN ONLY

- Swollen testes
- Testicular pain
- Feeling of coldness or numbness in external genitalia
- Testicular pain
- Impotence
- Premature ejaculation
- Other __________________________

EVERYONE: MEDICATIONS, VITAMINS AND SUPPLEMENT LOG

Medical/Allergy alerts: __________________________

___________________________________________

<table>
<thead>
<tr>
<th>Date Started</th>
<th>Medication/Vitamin/Supplement</th>
<th>Reason for taking</th>
<th>Dosage</th>
<th>Quantity</th>
<th>Frequency</th>
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<tbody>
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</table>
**DIETARY INTAKE**

Please list typical foods eaten for each meal and amount of beverages consumed each day of the following:

<table>
<thead>
<tr>
<th>Diet:</th>
<th>Beverages/Day:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast:</td>
<td>Water:</td>
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<tr>
<td>Lunch:</td>
<td>Pop:</td>
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<td>Dinner:</td>
<td>Milk:</td>
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<td>Snacks:</td>
<td>Juice:</td>
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<td>Coffee:</td>
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<td>Tea:</td>
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<td>Alcohol:</td>
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