Far Hills Acupuncture

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Patient Name ________________________________ Age ________ Date of Birth ____________

Main Complaints 1____________________ 2 ____________________ 3 ___________________

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Other Concurrent Therapies ____

Past Medical History

General

☐ Poor appetite ☐ Heavy appetite ☐ Change in appetite (how) ____________________

☐ Poor sleep ☐ Heavy sleep ☐ Insomnia ☐ Trouble falling asleep

☐ Waking at night ☐ Trouble waking ☐ Trouble going back to sleep ☐ Hours of sleep ________

☐ When to bed ________ ☐ When to wake __________ ☐ Dreams ☐ Fatigue

☐ Tremors ☐ Vertigo ☐ Cold hands ☐ Cold feet

☐ Cold back ☐ Cold abdomen ☐ Fevers ☐ Chills

☐ Night sweats ☐ Sweat easily ☐ Cravings ☐ Localized weakness

☐ Poor coordination ☐ Sudden energy drop ☐ Sudden increase in energy ☐ Peculiar tastes or smells

☐ Strong thirst ☐ Bleeding or bruising easily ☐ Best time of day ________ ☐ Worst time of day ______

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Skin & Hair

☐ Dandruff ☐ Eczema ☐ Hives ☐ Itching

☐ Pimples ☐ Purpura ☐ Rashes ☐ Ulcerations

☐ Changes in hair/skin texture____________________ ☐ Other hair or skin problems ______________________

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Head, Eyes, Ears, Nose & Throat

☐ Dizziness ☐ Concussions ☐ Earaches ☐ Ringing in ears

☐ Poor hearing ☐ Facial pain ☐ Facial paralysis ☐ Eye strain

☐ Eye pain ☐ Poor vision ☐ Blurry vision ☐ Night blindness

☐ Color blindness ☐ Cataracts ☐ Spots in eyes ☐ Nosebleeds

☐ Sinus problems ☐ Mucus ☐ Dry throat ☐ Dry mouth

☐ Copius saliva ☐ Teeth problems ☐ Gum problems ☐ Jaw clicks

☐ Grinding teeth ☐ Sores on lips or tongue ☐ Recurrent sore throats ☐ Migraines

☐ Headaches ☐ Other head or neck problems ____

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Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Irregular heartbeat

☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet

☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other ______________

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Respiratory

- ☐ Cough
- ☐ Coughing up blood
- ☐ Production of phlegm
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tight chest
- ☐ Difficulty when laying down
- ☐ Other lung problems ____________________

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Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Gas
- ☐ Belching
- ☐ Constipation
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Black stools
- ☐ Sensitive abdomen
- ☐ Pain or cramps
- ☐ Bloody stools Odor
- ☐ Hemorrhoids
- ☐ Laxative use
- ☐ Undigested food

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Genitourinary

- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Unable to complete
- ☐ Dribbling
- ☐ STD
- ☐ Urinary Tract Infection
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Wake to urinate

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Gynecology and Pregnancy

- Age at first menses _____
- ☐ Pregnancies #_______
- ☐ Irregular periods
- ☐ Menopause
- Last PAP _____________
- ☐ Births # _______
- ☐ Painful periods
- ☐ Clots
- Last Menses __________
- ☐ Miscarriages # ______
- ☐ Vaginal Discharge
- ☐ Breast lumps
- ☐ Birth control
- ☐ Premature births
- ☐ Changes in body / psyche prior to menstruation

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Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily stressed
- ☐ Treated for emotional problems
- ☐ Considered / attempted suicide
- ☐ Other neurological or psychological problems ____________________

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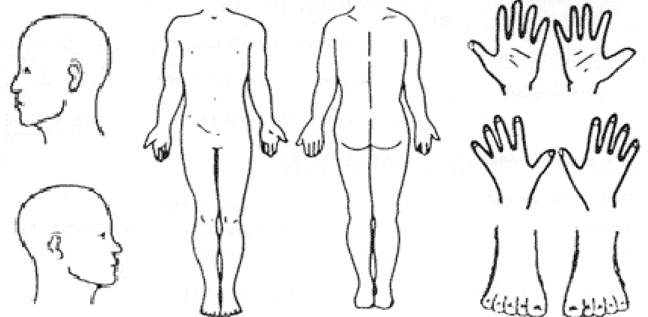
Musculoskeletal

- ☐ Neck pain
- ☐ Better / worse with heat
- ☐ Limb pain
- ☐ Better / worse with cold
- ☐ Back pain
- ☐ Better / worse with movement
- ☐ Muscle pain
- ☐ Better / worse with pressure
- ☐ Joint pain
- ☐ Fixed location
- ☐ Sharp quality
- ☐ Dull quality
- ☐ Distending quality
- ☐ Radiating quality
- ☐ Burning quality
- ☐ Stabbing quality

Mark Location of Pain or injury



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Significant Illnesses (list date of diagnosis)

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease
☐ Hepatitis ☐ Rheumatic Fever ☐ Thyroid Disease ☐ Seizures
☐ HIV ☐ Other ____________________
☐ Surgeries (type and date) ____________________
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☐ Significant trauma (type and date) ____________________
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Miscellaneous Information

Birth History (prolonged labor, premature, forceps delivery, etc.)____________________
Allergies (drugs, chemicals, food, etc.) ____________________
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Medication (name and dosage, include vitamins and herbs) ____________________
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Occupational Stresses (chemical, physical, psychological) ____________________
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Exercise (type and frequency) ____________________
Average daily diet (list morning, afternoon, and evening) ____________________
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☐ Smoke , how much ____________ ☐ Caffeine , how much ____________
☐ Alcohol, how much ____________ ☐ Drugs, how much ________, type ________

Family History

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease
☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies
☐ Alcoholism ☐ Multiple sclerosis ☐ Other ____________________
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Notes (please add anything of note)

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