Point of Health
Acupuncture

Today's Date: _____

Name: _____ DOB ___/ ___/____ Sex: M F

Address: _____ City _____ State: ____ Zip: _____

Best Phone Number: _____ Alternate Number: _____

Email Address: _____

Emergency Contact Name & Number: _____

Occupation: _____ Height: _____ Weight: _____lbs.

Name of your physician: _____

1. What brought you here today? _____

2. When did you first notice this problem? What symptoms did you notice?

_____

_____

3. What previous medical tests, diagnosis and/or treatment have you had for this problem? How has treatment helped?

_____

_____

4. Please list any allergies to drugs, medications, or food:_____

5. Please list any medications or supplements you are currently taking:

Medication	**How long have you taken it?**	**Dose**

6. Other serious illnesses, surgeries, injuries?

Date:	**Injury/Illness/Surgery**	**Treatment**	**Result**

7. Family history

☐ Allergies ☐ Diabetes ☐ Glaucoma ☐ Emotional Difficulties ☐ Seizure Disorders
☐ Heart Problems ☐ Cancer ☐ Stroke ☐ Hypertension/High BP ☐ Tuberculosis

8. Please check any conditions or symptoms that **you presently have** or **have had in the past:**

GENERAL

Past	Present	Condition
☐	☐	Poor appetite
☐	☐	Excess appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Night sweats
☐	☐	Sweat easily
☐	☐	Chills
☐	☐	Poor coordination
☐	☐	Bleed/bruise easily
☐	☐	Catch cold easily
☐	☐	Strong thirst

CARDIOVASCULAR

Past	Present	Condition
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Cold hands/feet
☐	☐	Fainting
☐	☐	Difficult breathing
☐	☐	Swelling hands/feet
☐	☐	Murmur
☐	☐	Other_____

FEMALE

Past	Present	Condition
☐	☐	Frequent urinary tract infection
☐	☐	Frequent vaginal infections
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Irregular/painful periods
☐	☐	Abnormal bleeding
☐	☐	Hot flashes
☐	☐	Ovarian cysts
☐	☐	Fibroids
☐	☐	Endometriosis
☐	☐	STD

SKIN/HAIR

Past	Present	Condition
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Dryness
☐	☐	Tumors/lumps
☐	☐	Dry/brittle nails
☐	☐	Yellow nails
☐	☐	Foot fungus

RESPIRATORY

Past	Present	Condition
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	COPD
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Phlegm or congestion
☐	☐	Winded easily
☐	☐	Tuberculosis
☐	☐	Pulmonary edema
☐	☐	Whooping cough

NEUROLOGICAL/PSYCHO-EMOTIONAL

Past	Present	Condition
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness/tingling of limbs
☐	☐	Multiple concussion
☐	☐	Facial pain
☐	☐	Paralysis
☐	☐	Depression
☐	☐	Anxiety/Stress
☐	☐	Irritabiity
☐	☐	Teeth grinding/clenching
☐	☐	Other _____

HEAD/NECK & EARS

Past	Present	Condition
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck stiffness/pain
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Ear infection
☐	☐	Ringing in ears
☐	☐	Decreased hearing
☐	☐	Other: _____

GASTROINTESTINAL

Past	Present	Condition
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Blood in stools/b lack
☐	☐	Constipation
☐	☐	Gas
☐	☐	Rectal pain/cramps
☐	☐	Hemorrhoids
☐	☐	Bad breath
☐	☐	Hearburn/acid reflux

INFECTION SCREENING

Past	Present	Condition
☐	☐	HIV
☐	☐	Hepatitis type: _____
☐	☐	Chlamydia
☐	☐	Gonorrhea
☐	☐	Syphilis
☐	☐	Genital warts
☐	☐	HPV
☐	☐	Herpes: oral
☐	☐	Herpes: genital
☐	☐	Lymes disease

EYES

Past	Present	Condition
☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Glasses/contacts
☐	☐	Eye inflammation
☐	☐	Other:_____

GENITO-URINARY

Past	Present	Condition
☐	☐	Kidney stones
☐	☐	Pain on urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Strong smelling urine
☐	☐	Other:_____

MUSCULO-SKELETAL

Past	Present	Condition
☐	☐	Stiff neck/shoulders
☐	☐	Low back pain
☐	☐	Muscle spasm or cramps
☐	☐	Sore, cold, or weak knees
☐	☐	Joint pain or stiffness
☐	☐	Muscle weakness
☐	☐	Fibromyalgia
☐	☐	Other: _____

FOR WOMEN:

1. Are you pregnant now? □ Yes □ No □ Unsure

2. Indicate number of occurrences: Live Births: _____ Pregnancies:_____ Miscarriages:_____ Abortions:_____

3. Age: First period _____ Onset of menopause: (if applicable) _____

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____

5. Any History of an Abnormal Pap Smear? □ Yes □ No If so, what / when? _____

6. Is your menses cycle regular? □ Yes □ No

a) Average number of days of flow _____

b) The flow is: □ Normal □ Heavy □ Light

c) The color is: □ Normal □ Dark □ Purple □ Light Brown □ Brown

7. Do you have any of the following menstrual/reproduction related signs/symptoms?

□ Cramps □ PMS □ Vaginal discharge □ Difficulty with orgasm □ Pain with intercourse

□ Nausea □ Menstrual blood clots □ Breast distention □ Spotting between periods □ Emotional

FOR MEN:

1. Do you have any bothersome urinary symptoms? □ Yes □ No

If yes, please describe: _____

2. Check all that apply:

□ Erectile dysfunction □ Pain in testicles □ Difficulty with orgasm □ Frequent nighttime urination

□ Premature ejaculation □ Swelling of testicles □ Low sperm count □ Dribbling urination/weak stream

3. Do you get up at night to urinate? □ Yes □ No How often? _____

4. Have you sought Medical intervention for these problems? If so, when? _____

5. What treatments have you tried for these problems and how successful have they been?_____

_____

Lifestyle:

Smoking: □ Yes □ No How often? How much? _____

Alcohol: □ Yes □ No How often? How much? _____

Recreational Drug Use: □ Yes □ No How often? How much? _____

Nutrition:

What do you typically eat for the following:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How much water do you drink per day?_____

How much caffeine do you drink per day?_____

Exercise:

What is your daily activity level related to your occupation:

□ Sedentary i.e mostly sitting □ somewhat active
□ moderately active □ very active (moving around or up most of the time)
□ heavy duty (lifting, moving thingd etc.)

Do you exercise? □ Yes □ No What do you do? _____ How often?_____

Is there anything else you think we should know about you in order to provide you with the best care?

_____

_____

_____