Please Print

Last Name _____ Frist name _____ Middle name _____ Date ___/___/___

Address _____ City _____ State _____ Zip _____-_____

Phone No. (___) _____-_____ Work No. (___) _____-_____ Date Of Birth ___/___/___

Sex (F, M) Height _____' _____" Weight _____ Lb. S.S.# _____ Refered By _____

Married ( ) Single ( ) Widowed ( ) Divorced ( ) Separated ( ) Other ( )

Type of Work _____ Can You Be Called At Work? Y( ) N( ) # of Children _____

Purpose of this appointment _____

Major Health Complaint _____

_____

_____

Health Professionals Seen For This Condition _____

How, When, Where did this condition begin _____

_____

_____

How does This Condition Impair Your Daily Activities _____

_____

All Medications /Vitamins You Now Take _____

_____

_____

Previous Acupuncture Yes [ ] No [ ]

List All Major Accidents, Falls, Major Surgeries, Hospitalizations.

Etc. _____

_____

IN THE PAST SIX MONTHS

[ ] Acne
[ ] Insomnia
[ ] Depression
[ ] Colitis
[ ] Tension Headaches
[ ] Painful Scars

[ ] Arthritis
[ ] Tendonitis
[ ] Bursitis
[ ] Impotence
[ ] Cystitis
[ ] General Malaise

[ ] Acute Sprain/Strains
[ ] Eczema/psoriasis
[ ] Sterility
[ ] Painful Condition
[ ] Fatigue
[ ] Urinary Incontinence

CHECK ALL OF THE FOLLOWING **YOU HAVE EVER HAD**

[ ] pneumonere
[ ] Anemia
[ ] Lumbago / Sciatica
[ ] Rheumatic Fever
[ ] Nerve Deafness
[ ] Heart Disease
[ ] Cancer
[ ] Migraines
[ ] Paralysis

[ ] Chicken Pox
[ ] Tuberculosis
[ ] Pleurisy
[ ] Mononucleosis
[ ] Diabetes
[ ] Thyroid Disorder
[ ] Epilepsy
[ ] C.V.A. (Stroke)
[ ] Emphysema

[ ] Polio
[ ] Shingles
[ ] Small Pox
[ ] Multiple Sclerosis
[ ] Asthma
[ ] Hepatitis-Year:_____
[ ] Emotional Disorder
[ ] Meniere's Disease
[ ] Whiplash

Do You Smoke Cigarettes ? ..... _____/ (# Per Day)

Do You Drink Coffee ?..... _____/ (# Cups Per Day)

Level of daily Stress..... _____/ (0 - 10)

Drink Alcohol..... _____/ (# Drinks per week)

How Many Hours Per Week Do You Work ?_____ Do Weather Conditions Affect Your Condition ?_____

What Are The Main Stress Factors In Your Life ?_____

What Are The Main Ways You Relax And Reduce Stress ?_____

What Type Of Exercise Do You Presently Participate in ?_____

Please List The Main Health Problems You Would Like To Be Free Of In Order Of Importance:

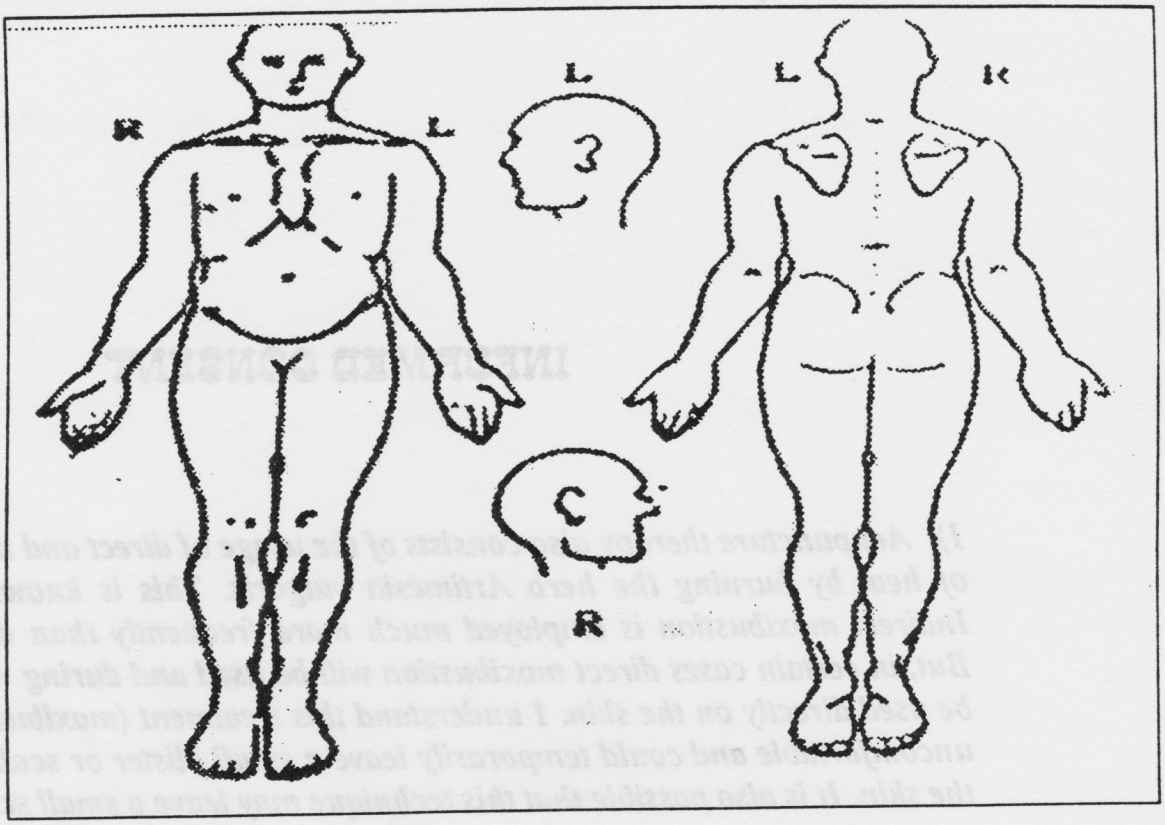
1._____

2._____

3._____

Please Describe Your Health, And Any Other Additional Comments.

PLEASE MARK OR COLOR IN ALL AREAS OF PAIN OR DISCOMFORT ON THE DIAGRAM TO THE RIGHT



WOMEN ONLY *FILL IN BELOW THIS LINE*

Are you Pregant ?.....Yes [ ] No [ ]
Have you experienced monopause ?.....Yes [ ] No [ ]
Have you had a hysterectomy ?.....Yes [ ] No [ ]
Are you prone to vaginal infections ?.....Yes [ ] No [ ]
Is your period irrgular ?.....Yes [ ] No [ ]
Are you tired and/or depleted after your period ?.....Yes [ ] No [ ]
Do you feel you have P.M.S. ?.....Yes [ ] No [ ]

Date of your last period ..... ___/___/___

The usual interval between periods ?..... _____ *days*

How long does your period last ?..... _____ *days*

Is your flow.....*Heavy* [ ].....*Moderate* [ ].....*Light* [ ]

What color best describes your flow _____

PLEASE DO NOT WRITE IN THIS BOX

ACUPUNCTURIST'S COMMENTS: _____

_____

_____

DX.: _____

TX. PLAN: _____

SIGNED: _____