PERSONAL INFORMATION

Name:____ Date:________________
Home Address:____
City:____ State:____________ Zip:_______________
Home Phone:_________________________ Email:____
Work Phone:__________________________ Occupation:____
Emergency Contact:______________________________ Phone:___________________________________
Whom should we thank for referring you to this office?_______________________________________
Sex: Male__ Female__ **Marital Status:** Married__ Single__ Divorced__ Widowed__

Have you received acupuncture therapy before? Yes/No

When?_________________________________ With Whom?____________________________

Please indicate any significant illnesses you or a blood relative (Grandparent, parent, sibling) have had:

Illness	**You**	**Your Relative**	**Approx. Date**		**Illness**	**You**	**Your Relative**	**Approx. Date**
Cancer					Diabetes			
Hepatitis					Heart Disease			
High Blood Pressure					Seizures			
Rheumatic Fever					Emotional Disorders			
Infectious Diseases					Tuberculosis			

Sexually Trans. Diseases: Gonorrhea__ Syphilis__ AIDS__ HPV__ Chlamydia__ Herpes__ DATE:______

List any medications and supplements you are currently taking:

Medicine	**Dosage**	**Reason**	**How Long**	**Prescribed By**	**Date of Last Checkup**

Check if any of the following statements are true:		I have known allergies.____	I have a pacemaker.____
I am taking Coumadin/warfarin.______	I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)____		

Please indicate the use and frequency of the following:

Substance:	**Yes**	**No**	**How much**	**Substance:**	**Yes**	**No**	**How Much**	**Substance:**	**Yes**	**No**	**How much**
Coffee/Black Tea				Tobacco				Water Intake			
Non Medical Drugs				Alcohol				Soda Pop			

What are the main health problems for which you are seeking treatment? ______________________________ ____ ____ ____	Practitioner's Use **CLINICAL NOTES**
What other forms have you sought? ________________ ____ ____ ____	
List any other health problems you now have. ________ ____ ____ ____ ____	
List any allergies, food sensitivities, or food cravings you now have. ______________________________________ ____ ____ ____	
List any accidents, surgeries, or hospitalizations (include date). ____ ____ ____ ____	
Lab results. _______________________________________ ____ ____ ____	

How do you FEEL about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	**Good**	**Fair**	**Poor**	**Bad**	**Your Comments**
Significant Other						
Family						
Diet						
Sex						
Work						
Exercise						
Spirituality						

Measure Yourself Medical Outcome Profile (MYMOP)

Name:____ Date: ___________________________

Choose one or two symptoms (physical or mental) which bother you the most. Now consider how severe each symptoms has been over the past week and score it by circling the number that most accurately represents your pain.

SYMPTOM 1: ____

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS BAD AS IT COULD BE

SYMPTOM 2: ____

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS BAD AS IT COULD BE

Choose one activity (physical, social, or mental) that is important to you, and that your problem makes difficult or prevents you from doing. Score how badly this activity has been affected in the past week due to your problem.

ACTIVITY: ____

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS BAD AS IT COULD BE

How would you rate your general feeling of well-being during the past week?

AS GOOD AS IT COULD BE	**0**	**1**	**2**	**3**	**4**	**5**	**6**	AS GOOD AS IT COULD BE

How long have you had Symptom 1, either all the time or on and off?

0 – 4 WEEKS   4 – 12 WEEKS   3 MONTHS – 1 YEAR   1 – 5 YEARS   OVER 5 YEARS

Are you taking any medication FOR THIS PROBLEM? Please circle: **YES / NO**

IF YES, Please write name of medication and how often it is taken:

____

How important to you is cutting down the medication?

NOT IMPORTANT   A BIT IMPORTANT   VERY IMPORTANT   NOT APPLICABLE

IF NO, How important to you is avoiding medication for this problem?

NOT IMPORTANT   A BIT IMPORTANT   VERY IMPORTANT   NOT APPLICABLE

For Women

Age of 1st period (menarche) ________ Are you pregnant? Y / N Number of pregnancies: ___________________

Age of last period (menopause): ______ # of live births _____ # of abortions: _____ # of miscarriages: _________

Number of days between periods: ____ Date of last: Gynecologic Exam __________ Pap Smear: ___________________
Number of days of flow: ____________ Mammogram: _______________________ Bone Density Scan: ___________
Color of flow: _____________________ Results: ____
Clots? Y / N Color ________________ ____
Average number of pads you use per day: 1st day_____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Fibroids__ Fibrocystic Breasts__ Ovarian Cysts__ PID__ **Other**_________
Location of pain: Lower abdomen__ Lower back__ Thighs__ Other ______________________________________

Nature of Pain (Please indicate before, during, or after menses)		**Other symptoms related to menses:**		
Cramping __________	Cramping____________	Discharge__	Vaginal Dryness__	Headache__
Burning____________	Burning_____________	Nausea__	Constipation__	Diarrhea__
Dull_______________	Dull________________	Swollen breasts__	Mood Swings__	Ravenous Appetite__
Consistent__________	Consistent__________	Poor appetite__	Hot flashes__	Night Sweats__
Bearing down sensation____________________		Increased Libido__	Decreased libido__	Insomnia__

For Men

Date of last prostate checkup__________ PSA results____________ Manual prostate exam results______________
Lab results____
Frequency of urination: Daytime____ Nighttime____ Color of urine: Clear__ Murky__ Odor:_____________

Symptoms relate to prostate:

Prostate problems___	Delayed stream___	Dribbling___	Incontinence___	Retention of urine___
Rectal dysfunction___	Increased libido___	Decreased libido___	Premature ejaculation__	Impotence___
Back pain___	Groin pain___	Testicular pain___	Other___________________________________	

SYMPTOM SURVEY (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark( ) = never experience **Check mark** () = sometimes experience **Plus sign** (+) = frequently experience

___lack of appetite
___excessive appetite
___loose stool or diarrhea
___digestive problems, indigestion
___vomiting
___belching, burping
___heartburn/reflux
___feeling the retention of food in the stomach
___tendency to become obsessive in work, relationships, etc
___insomnia, difficulty sleeping
___heart palpitations
___cold hands and feet
___nightmares

___laughing for no apparent reason
___angina pains
___abdominal pain
___chest pain
___sciatic pain
___headaches
___pain or coldness in genital area
___cough
___shortness of breath
___decreased sense of smell
___nasal problems
___skin problems
___feeling of claustrophobia
___bronchitis
___colitis or diverticulitis
___constipation
___hemorrhoids

___recent use of antibiotics
___eye problems
___jaundice (yellowish eyes or skin
___difficulty digesting oily foods
___gall stones
___light colored stool
___soft or brittle nails
___easily angered/agitated
___difficulty in making plans or decisions
___spasms or twitching of muscles
___low back pain
___knee problems
___hearing impairment
___ear ringing
___kidney stones

___decreased sex drive
___hair loss
___urinary problems
___fatigue
___edema
___blood in stool
___black tarry stool
___easily bruised
___difficult to stop bleeding
___asthma
___tendency to catch colds
___intolerance to weather changes
___allergies
___hay fever
___dizziness
___tendency to faint easily
___high cholesterol levels
___sudden weight loss