Inner Court Acupuncture

Name_____ Today's Date _____/_____/_____

Address _____

Home ph._____ Work ph._____e-mail_____

Birthdate ____/ ____/ ____ Marital Status ◯Single ◯Married / Partnered ◯Divorced ◯Widowed

Occupation _____ Any children?_____

Emergency contact _____ Phone _____

Had acupuncture before?◯Y ◯N Reason for visit today _____

How long have you had this condition?_____ Onset was◯ sudden ◯gradual

What was the initial cause?_____ Is it getting worse? _____

What makes it better? _____ Worse? _____

Does it bother your: ☐Sleep ☐Work ☐Activities ☐Mood Level of Pain (1 – 10) _____

Any medical diagnosis received? _____

Who is your physician? _____ Phone _____

Family Health History

☐Allergies
☐Arteriosclerosis
☐Asthma
☐Alcoholism/Drug Abuse
☐Cancer
☐Diabetes
☐Heart Disease
☐High Blood Pressure
☐Intestinal Disorder
☐Psychiatric Condition
☐Seizures
☐Stroke
☐Other _____

Your Health History

☐Aids/HIV
☐Alcohol/Drug Abuse
☐Allergies
☐Anemia
☐Appendicitis
☐Arteriosclerosis
☐Asthma
☐Birth trauma
☐Bronchitis
☐Cancer
☐Chicken Pox
☐Colitis/IBS
☐Diabetes
☐Emphysema
☐Epilepsy
☐Gallstones
☐Gout
☐Hepatitis
☐Herpes
☐High / Low Blood Pressure
☐Lyme Disease
☐Mitral Valve Prolapse
☐Multiple Sclerosis
☐Pacemaker
☐Pleurisy
☐Pneumonia
☐Polio
☐Rheumatic Fever
☐Rheumatoid Arthritis
☐Reynaud's Disease
☐Scarlet Fever
☐Seizures
☐Shingles
☐Stroke
☐Thyroid Disorder
☐Tuberculosis
☐Ulcers
☐Venereal Disease
☐Whooping Cough
☐Other _____

List Surgeries: _____
_____
_____
_____

List Major Traumas:
_____
_____
_____
_____

Your Diet

☐Appetite Low
☐Appetite High
☐Caffeinated drinks
☐Soft Drinks
☐Artificial Sweetener
☐Crave sugar/starches
☐Crave salty foods
☐Vegetarian

# of glasses of water per day _____

Average Daily Menu

Breakfast _____ Lunch_____ Dinner _____ Snacks_____
_____ _____ _____ _____
_____ _____ _____ _____

Pharmaceuticals taken in last 2 months:_____
_____

Vitamins/herbs/supplements taken in last 2 months: _____
_____

(over)

Your Lifestyle

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Drugs
- ☐ Stress
- ☐ Occupational hazards
- ☐ Regular exercise

General Symptoms

- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Recent weight loss / gain
- ☐ Insomnia
- ☐ Heavy sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Body feels heavy
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Frequent fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Muscle cramps
- ☐ Tremors/shaking
- ☐ Vertigo or dizziness
- ☐ Bleed or bruise easily
- ☐ Peculiar taste_____

Head, Eyes, Ears, Nose, Throat

- ☐ Eye pain
- ☐ Red/itchy eyes
- ☐ Spots in eyes
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Teeth clenching/grinding
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Excessive phlegm/mucus
  Color _____
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Poor hearing
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions

Other head or neck problems:

_____

_____

_____

Respiratory

- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Asthma/wheezing
- ☐ Frequent colds/flus
- ☐ Coughing blood
- ☐ Cough

Wet or dry? _____
Color of phlegm _____

Cardiovascular

- ☐ Blood clots
- ☐ Fainting
- ☐ Chest pain
- ☐ Difficulty breathing
- ☐ Tachycardia
- ☐ Heart palpitations
- ☐ Phlebitis
- ☐ Irregular heartbeat

Gastrointestinal

- ☐ Nausea/vomiting
- ☐ Acid reflux
- ☐ Hiatal hernia
- ☐ Gas
- ☐ Bloating
- ☐ Bad breath
- ☐ Feel tired after eating
- ☐ Intestinal pain/cramping
- ☐ Diarrhea
- ☐ Regular loose stools
- ☐ Constipation
- ☐ Laxative use
- ☐ Black stools
- ☐ Bloody stools
- ☐ Mucus in stools
- ☐ Itchy/burning anus
- ☐ Hemorrhoids/fissures
- ☐ Eating disorder

Bowel movements:
Frequency _____
Form _____
Color _____

Musculoskeletal/Neural

- ☐ Neck/shoulder pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle pain/sprain
- ☐ Herniated discs
- ☐ Sciatica
- ☑ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome

Other _____
_____

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair loss
- ☐ Dry skin

Other skin/hair issues ____
_____

Neuropsychological

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Periods of depression
- ☐ Frequent anxiety
- ☐ Easily irritable
- ☐ Easily stressed
- ☐ History of abuse
- ☐ Seeing a therapist

Other _____
_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Unable to hold urine
- ☐ Incomplete urination
- ☐ Wake to urinate
- ☐ Blood in urine
- ☐ Infertility
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Kidney stones
- ☐ Prostate condition

Gynecological

- ☐ Vaginal discharge
  Color _____
- ☐ Vaginal sores
- ☐ Vaginal odor
- ☐ Breast lumps
- ☐ Fibroids/cysts

# of pregnancies _____
# of births_____
- ☐ Menopausal symptoms

Age of menopause _____
Age menses began _____
# of days of flow_____

Length of cycle _____
- ☐ Irregular periods
- ☐ PMS
- ☐ Painful periods
- ☐ Clotting with flow
- ☐ Amenorrhea

Date of last PAP _____

Are you pregnant or trying to get pregnant? ○ Y ○ N

What are you hoping to achieve with treatment? _____

_____

_____