

Integrative Healing Arts Acupuncture, P.C.



Acupuncture
Herbal Medicine
Massage Therapy
917-294-3805

Note: information provided on this form is confidential.

Today's Date ___/___/___

Name: _____ Age: _____ Sex: Male Female

Address _____ Occupation _____

City _____ State _____ Zip _____ Date of birth ___/___/___

Telephone: Day _____ Ext. _____ Evening: _____ e-mail _____

How did you hear about us? _____

Under a physicians care? _____ Name & phone of physician: _____

What would you like treated by Acupuncture? _____

How long have you had this condition? _____ Was onset sudden gradual

Symptoms are worse by _____ Symptoms better by _____

What medical diagnosis have you received? _____

What other treatments have you received for this and/or other conditions? _____

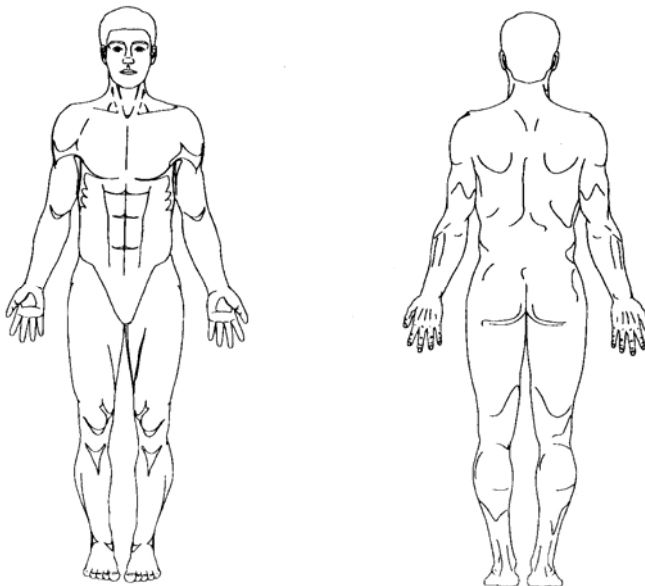
How has this condition changed your life? _____

Are you taking any medication? Please note all medication, herbs, vitamins and minerals you take even if you take them only occasionally. _____

Are you currently pregnant? Yes No

Are you presently trying to get pregnant? Yes No

On the following drawing shade the areas which you feel should be addressed.





Medical History

Birth: Anything significant about your birth? _____

Vaccination history: Any reaction that you remember? Any unusual vaccination? _____

Childhood illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Adolescence illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Adulthood: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

_____ age: _____

_____ age: _____

_____ age: _____

Family history: please note all major illnesses in your close family such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.



Underline current conditions. Put a check mark in the box for former conditions. Add any additional information regarding duration, frequency, intensity and pain regarding current symptoms.

Have you had any of these?

- AIDS/HIV Cancer Lyme Disease Seizures
- Alcoholism Diabetes Multiple Sclerosis Tuberculosis
- Allergies Emphysema Pacemaker Polio
- Asthma Heart Disease Lymph nodes removed Rheumatic Fever
- Hepatitis A/B/C Scarlet Fever Headache Birth Trauma
- Herpes Other _____ (your own birth)

Diet and Food:

How is your appetite? Good Poor No appetite Hungry all the time

Any food cravings?: _____

List any food intolerances: _____

Describe meals for a typical day: Breakfast _____

Lunch: _____ Dinner: _____

How often do you have: meat _____ day/wk Coffee or Tea (caffeinated) _____ day/wk

Sugar/Sweets _____ day/wk Dairy (milk, cheese, yogurt) _____ day/wk

Are you always thirsty? Yes No Do you prefer Hot or Cold drinks?

How many glasses/cups do you have daily: Water _____ soda _____ Coffee/Tea _____

Alcohol _____ day/wk

Do you have unusual sweating? When? _____ other _____

Rate your taste preferences 1 to 5 (1=like most to 5=dislike):

Salty _____ Sour _____ Bitter _____ Sweet _____ Spicy _____

Exercise and Energy:

How is your energy? _____

What time of day is your energy: Highest? _____ Lowest _____

Do you fatigue easily? _____

Does movement make you feel : less tired or more tired

What kind of exercise do you do? _____

How often do you exercise? _____



Emotions and Sleep:

How do you feel emotionally? _____

Do you have (check all that apply): Panic attacks Depression Anxiety Bad Temper

Nervousness Fear attacks Poor memory Difficult concentration

Other: _____ Married or Stable relationship Single

How do you feel about your relationship? _____

How do you hold stress? _____

How do you relax? _____

How do you feel about your work? _____

Do you use any prescription or non-prescription substances? Anti-depressants Sleeping pills

Other: _____

How long do you normally sleep? _____ hours per night

I have difficulty with (check all that apply): Falling asleep Staying asleep Disturbed Sleep

Waking up at about _____ am/pm and not being able to fall asleep again because

Skin and Hair:

I have (check all that apply): Dry skin Skin rashes Itching Acne Eczema Hives

Hair loss Premature graying Other: _____

Respiratory, Eyes, Ears, Nose, Throat & Head:

Do you smoke? Yes No _____ per day, for _____ years

I have (check all that apply): Frequent colds Chronic runny nose Chronic cough

Coughing blood Pain inhaling Shortness of breath on exertion/at rest Asthma Nose bleeds

Pain/red eyes Poor vision See spots Dizziness Cold sores Bleeding gums Dry mouth

Ear pain Ringing in ears Clogged/popping ears

Frequent sore throat Cough up mucous How much? _____ Color of phlegm? _____

Frequent headaches/migraines Describe: _____

Other: _____



Cardiovascular:

Blood pressure: ____/____ Have you been diagnosed with heart trouble? Yes No

I have (check all that apply): Chest pain Palpitations Irregular heart beat Phlebitis

Varicose veins Cold hands and feet Poor circulation

Gastrointestinal:

I have (check all that apply): Belching Nausea Vomiting Vomiting of blood Ulcers

Acid regurgitation Heartburn Hernia Indigestion Severe stomach pains

Other : _____ Bowel movements: How often? _____ day/week

Painful bowel movement? Yes No

I have (check all that apply): Irregular Constipation Diarrhea Gas Burning Hemorrhoids

Use laxatives Undigested food in stool Loose stool Hard stool Blood in stool Itchiness

Other: _____

Muscles, Joints and Bones:

Do you have pain or tightness? Where? _____

The pain is (check all that apply): Sharp Aching Numb Deep pain Burning Dull

Superficial pain Tingling Pain worse or better with heat Pain worse or better with cold

Pain worse in am or pm

I have (check all that apply): Swollen joints Arthritis/joint pain Tendinitis Rheumatism

Bone pain Muscle cramping Muscle pain Repetitive strain

Other: _____

Urinary & Genital:

Urination: How often? _____ times per day. Color. Pale yellow Dark yellow/orange

I have or have had (check all that apply): Trouble starting stream Frequent urination

Incontinence Trouble holding urine Pain Burning Dribbling when sneezing

Urinary tract infections Blood in urine Kidney stones Other: _____

How is your sexual energy? _____

What kind of birth control do you use? _____

Do you have (check all that apply): Infertility Pain during sexual relations:

Other: _____



Women:

At what age did you start menstruation? _____ Number of days between cycles: _____

Number of days of flow: _____ Color: _____ I have or have had (check all that apply):

Irregular menstruation Heavy flow Light flow No flow Clots

Vaginal itching/burning Spotting between periods Discomfort/pain before period

Discomfort/pain during period Other: _____

Any vaginal discharge? Yes No Amount _____ Color _____ Frequency _____

Lumps in the breast Congested breast Breast tenderness

Blood or mucous discharge from breasts? Yes No Amount _____ Frequency _____

PMS symptoms: _____

What makes these symptoms better? _____

Are you using birth control? What type? _____

Number of pregnancies? _____ Number of deliveries? _____ Abortion(s)/Miscarriage(s)? _____

Pregnancy complications? Please describe: _____

Menopausal Symptoms: _____

Reduced sexual energy? Yes No

Men:

I have (check all that apply): Prostatitis Impotence Penis blood/mucous discharge

Pain associated with genitals Premature ejaculation Reduced sexual energies

Seminal emission

Other: _____