

Acupuncture & Herbal Works  
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Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Chief Problem: \_\_\_\_\_

How long have you had it: \_\_\_\_\_

How did this condition develop: \_\_\_\_\_

What makes it worse: \_\_\_\_\_

What makes it better: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

List Surgeries (include date) \_\_\_\_\_

List significant traumas (physical or emotional): \_\_\_\_\_

**YOUR PAST MEDICAL HISTORY/ILLNESSES** (check all that apply):

- Alcoholism     Cancer     Diabetes     Gallstones     Drug Addiction     Stroke  
 Hepatitis     Heart Disease     High Blood Pressure     Seizures     Asthma  
 Pneumonia     Kidney Disease     Rheumatic Fever     Stroke

**FAMILY HISTORY**

- Abuse     Alcoholism     Asthma     Cancer     Diabetes  
 Drugs     Heart Disease     Stroke     Hypertension

**YOU NOW:**  Pregnant     Pacemaker     AIDS     Hepatitis     Blood transfusions

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Heaviness in the head | <input type="checkbox"/> Feel sad a lot                 | <b>TESTS</b>                                | periods                                     |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Persistent cough      | <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> X-rays             | <input type="checkbox"/> Irregular periods  |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Recurrent bronchitis  | <input type="checkbox"/> Much fear                      | <input type="checkbox"/> MRI                | <input type="checkbox"/> Heavy periods      |
| <input type="checkbox"/> Vertigo             | <input type="checkbox"/> High blood Pressure   | <input type="checkbox"/> Terrors                        | <input type="checkbox"/> CAT scan           | <input type="checkbox"/> Endometriosis      |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Difficulty expressing emotions | <input type="checkbox"/> Blood work         | <input type="checkbox"/> Painful periods    |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Night urineX__        | <input type="checkbox"/> Constipation                   | <input type="checkbox"/> _____              | <input type="checkbox"/> Vaginal discharges |
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Low sexual energy     | <input type="checkbox"/> Diarrhea/loose Stools          | <b>PAIN IN</b>                              | <input type="checkbox"/> Menopausal         |
| <input type="checkbox"/> Phlegm in throat    | <input type="checkbox"/> Night sweating        | <b>LIFESTYLE</b>  | <input type="checkbox"/> Arms               | <b>MEN ONLY</b>                             |
| <input type="checkbox"/> Recent clumsiness   | <input type="checkbox"/> Weight loss           | <input type="checkbox"/> Healthy diet                   | <input type="checkbox"/> Feet               | <input type="checkbox"/> Genital pain       |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Weight gain           | <input type="checkbox"/> Smoke cigarettes               | <input type="checkbox"/> Hands              | <input type="checkbox"/> Impotence          |
| <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Likes heat            | <input type="checkbox"/> Drink alcohol                  | <input type="checkbox"/> Joints             | <input type="checkbox"/> Genital sores      |
| <input type="checkbox"/> Sinus problems      | <input type="checkbox"/> Likes cold            | <input type="checkbox"/> Drink coffee                   | <input type="checkbox"/> Legs               | <input type="checkbox"/> Lump in testicles  |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Excess thirst         | <input type="checkbox"/> Eat a lot of sweets            | <input type="checkbox"/> Shoulders          | <input type="checkbox"/> Penis discharge    |
| <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Insomnia              |   | <input type="checkbox"/> All over           | <input type="checkbox"/> Nocturnal emission |
|  | <input type="checkbox"/> Irritability          |   | <b>WOMEN ONLY</b>                           |   |
|  |  |   | <input type="checkbox"/> Date last pap_____ |   |
|  |  |   | <input type="checkbox"/> Bleed between      |   |