THE COMMUNITY ACUPUNCTURE CENTER OF EASTHAMPTON

Name:_____ Date:_____

Street:_____ City:_____ State/Zip:_____

Phone:_____ Email:_____

Age:_____ Date of Birth:_____ Male/Female/Transgender/Other:_____

Relationship Status:_____ Height:_____ Weight:_____

Occupation:_____ Where did you hear about us:_____

Emergency Contact:_____Relation to you:_____ Phone:_____

Main condition(s) that you would like us to help you with:_____

_____

_____

How long ago did this condition(s) start?_____

_____

_____

Have you been given a diagnosis for this condition(s)? If so, what diagnosis and by whom?

_____

_____

Past Personal Medical History:

□ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke □ Heart disease

□ High Blood Pressure □ Seizures □ Hepatitis □ Rheumatic Fever

□ Thyroid disease Other:_____

Hospitalizations/Surgeries (please include dates):_____

_____

Significant Trauma (auto accidents, falls, injuries, etc):_____

_____

Allergies (drugs, chemicals, metals, foods):_____

_____

Medicines taken within the past two months and reasons for taking them (vitamins, drugs, herbs, etc):_____

_____

Do you have a regular exercise program? If yes, please describe. _____

_____

Do you follow any type of special diet (i.e. vegetarian, vegan, medical related or other)?_____

_____

Please describe your average daily diet:

Morning:_____

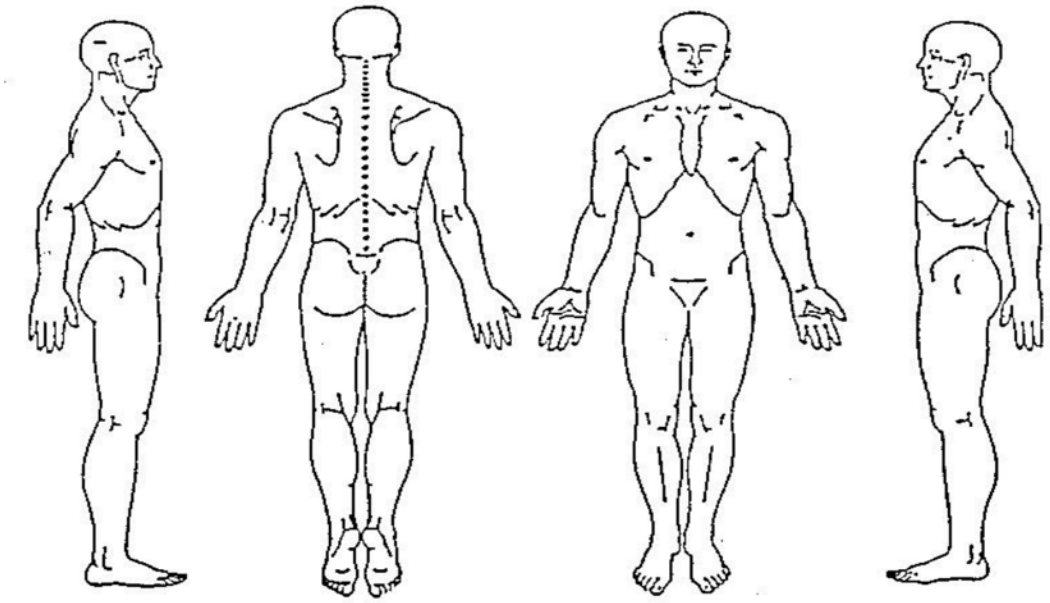
Lunch:_____

Dinner:_____

How many 8 oz glasses of water do you drink each day?_____

How many caffeinated beverages do you drink each week?_____

Please circle any areas on the body that are painful or troublesome:



Please check any condition that you have had in the past three months.

General:

□ Fevers □ Chills □ Fatigue □ Sweat easily □ Poor sleeping □ Night sweats □ Weight loss

□ Cravings □ Weight gain □ Change in appetite

□ Strong thirst for: □ Hot drinks □ Cold drinks

□ Sudden energy drop, if so what time of day?_____

□ Bleed or bruise easily □ Peculiar tastes or smells

Hair & Skin:

□ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Dandruff

□ Loss of hair □ Recent moles □ Psoriasis □ Dermatitis □ Acne

□ Change in hair or skin texture □ Any other skin or hair problems_____

Eyes, Ears, Nose, Throat & Head:

□ Dizziness □ Concussions □ Migraines □ Glasses □ Eye strain □ Eye pain □ Poor vision
□ Night blindness □ Color blindness □ Cataracts □ Blurry vision □ Earaches □ Ringing in ears
□ Spots in front of eyes □ Poor hearing □ Sinus problems
□ Nose bleeds □ Recurrent sore throats □ Grinding teeth □ Clenching jaw
□ Facial pain □ Sores on lips or tongue □ Teeth problems □ Jaw clicks
□ Headaches, where and when?_____
□ Any other head or neck problems?_____

Cardiovascular:

□ High blood pressure □ Low blood pressure □ Chest pain □ Fainting □ Irregular heart beat
□ Difficulty in breathing □ Blood clots □ Phlebitis □ Cold hands or feet □ Swelling of hands
□ Swelling of feet □ Varicose or spider veins □ Palpitations □ Palpitations at rest
□ Any other heart of blood vessel problems?_____

Respiratory:

□ Cough □ Coughing blood □ Asthma □ Bronchitis □ Pneumonia □ Pain with deep breath
□ Chest tightness □ Difficulty breathing when lying down
□ Phlegm production, what color?_____

Gastrointestinal:

□ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Belching □ Black stools
□ Blood in stools □ Indigestion □ Bad breath □ Rectal pain □ Hemorrhoids □ Bleeding gums
□ Food stagnation □ Bloating/edema □ Acid reflux/GERD □ Hernia □ Excessive appetite
□ Poor appetite □ IBS/Crohn's disease □ Colitis □ Slow digestion □ Abdominal pain/cramps
□ Chronic laxative use □ Loose stools, more than 2 per day
□ Any other problem with Stomach or intestines_____

Genito-Urinary:

□ Frequent urination □ Blood in urine □ Pain upon urination □ Urgency to urinate
□ Unable to hold urine □ Kidney stones □ Decrease in flow □ Impotency □ Sores on genitals
□ Any particular color to your urine? _____
□ Do you wake up at night to urinate? How many times a night? _____
□ Any other problems with your genital or urinary systems?_____

Reproductive & Gynecological:

Are you pregnant? □ Yes □ No
Is it possible that you are pregnant? □ Yes □ No
Number of pregnancies: _____ Live Births: _____ Miscarriages: _____
Abortions: _____ Premature births:_____

Age at first menses: _____ Time period between menses:_____

Duration of menses:_____ Last PAP: _____

□ Irregular periods □ Painful periods □ Clots □ Breast lumps □ Vaginal sores

□ Vaginal discharge □ Vaginal dryness □ Endometriosis □ Uterine fibroids

□ Polycystic Ovarian disease □ Fibrocystic breast tissue

□ Unusual character of blood (heavy, scanty)_____

Do you practice birth control? □ Yes □ No If yes, what type? _____ How long? _____

Musculoskeletal:

□ Neck pain □ Rotator cuff □ Knee pain □ Foot/ankle pain □ Muscle pain □ Muscle spasm

□ Muscle weakness □ Shoulder pain □ Hip pain □ Sciatica □ Bursitis □ Hand/wrist pain

□ Carpal tunnel □ Sprains/strains □ Tendonitis □ Back pain: Low_____ Middle_____ Upper_____

□ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

Neurological & Psychological:

□ Seizures □ Dizziness □ Loss of balance □ Areas of numbness □ Poor memory □ Concussion

□ Poor coordination □ Bad temper □ Anxiety □ Depression □ Easily susceptible to stress

□ Nervousness □ ADD/ADHD □ Manic depression

Have you ever been treated for emotional problems? □ Yes □ No

Have you ever considered or attempted suicide? □ Yes □ No

Any other neurological or psychological problems?_____