Colorado Complete Health for Women

Acupuncture Health Form

Patient Information

Name _____ Date _____

Address _____

Home Phone _____ Cell Phone _____

Height _____ Weight _____ SEX: ☐ Male ☐ Female Marital Status _____

Date of Birth _____ AGE _____

Occupation _____ Employer _____

Have you had acupuncture before? ☐ NO ☐ YES, Name of Acupuncturist _____

Major Complaint

Primary reason for your visit today? _____

Has this condition been diagnosed by a physician, or other provider? ☐ NO ☐ YES

If yes, what was the Diagnoses? _____

Are you being treated for this condition by anyone else? ☐ NO ☐ YES

If yes, what is the treatment? _____

Have these treatments helped? ☐ YES ☐ Somewhat ☐ Not Much ☐ Not At All

How does this condition affect you? _____

How long have you had this condition? _____

Personal Health History

Your general health as a child was? ☐ Excellent ☐ Good ☐ Average ☐ Poor

Did you feel safe and nurtured as a child? ☐Always ☐ Usually ☐Sometimes ☐Never

Check all the illnesses or conditions which you currently have or have had in the past:

☐AIDs / HIV	☐Eating Disorders	☐Kidney Disease	☐Rheumatic Fever
☐Alcoholism	☐Epilepsy	☐Measles	☐Scarlet Fever
☐Allergies	☐Glaucoma	☐Meningitis	☐Sexually Transmitted
☐Antibiotic Use	☐Heart Disease	☐Mental Illness	Disease
☐Asthma	☐Hepatitis	☐Multiple Sclerosis	☐Stroke
☐Bleed Easily	☐High Blood Pressure	☐Mumps	☐Tuberculosis
☐Cancer	☐High Fevers	☐Obesity	☐Typhoid Fever
☐Chicken Pox	☐Hyperthyroid	☐Pneumonia	☐Ulcers
☐Diabetes	☐Hypothyroid	☐Polio	☐ Vascular Disease
☐Drug Abuse	☐Jaundice	☐Other _____	

Are you taking Coumadin or Warfarin? ☐ NO ☐ YES

Do you have a pacemaker? ☐ NO YES

Do you currently have any infectious diseases? ☐ NO ☐YES ☐Possibly

If yes, please identify: ☐ HIV/AIDs ☐Hepatitis B ☐Hepatitis C ☐ Flu/ Cold ☐ Streptococcus ☐ Mononucleosis

☐ Tuberculosis ☐ Other _____

Known or suspected allergies: _____

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Please put a (✓) by the symptoms that you have now.
Place a (**x**) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang

☐anxiety
☐catches colds easily or frequently
☐chest pain traveling to shoulder
☐cold feet
☐cold hands
☐dizziness
☐dream disturbed sleep
☐dry skin
☐fatigue
☐feverish in the afternoon or flushes
☐ general weakness
☐heat sensations in hands, Feet, chest
☐insomnia
☐mental confusion
☐night sweats
☐palpitations
☐restlessness
☐sores on tip of tongue
☐speech problems
☐sweats easily
☐thirst, at night
☐you feel worse after exercise
☐you see floating black spots

LU

☐allergies
☐chills alternating with fever
☐cough
☐difficulty breathing
☐dry mouth, throat, nose
☐feeling achy
☐headaches
☐nasal discharge
☐nose bleeds
☐shortness of breath
☐sinus congestion
☐sneezing
☐stiff neck/ shoulders

SP

☐abdominal bloating and gas after eating
☐belching
☐chest congestion
☐diarrhea
☐eating disorders
☐fatigue after eating
☐gas
☐general feeling of heaviness in your body
☐hemorrhoids
☐loose stools
☐low appetite
☐mental heaviness
☐sluggishness or fogginess
☐nausea
☐prolapsed organs (previously diagnosed)
☐swollen feet
☐swollen hands
☐you bruise easily

ST

☐bad breath
☐belching
☐bleeding, swollen or painful gums
☐burning sensation after eating
☐constipation
☐heartburn
☐large appetite
☐mouth sores canker/cold sores
☐stomach pain
☐ vomiting

HT/PC

☐chest pain
☐ edema
☐high blood pressure
☐insomnia
☐low blood pressure
☐palpitations
☐stroke
☐varicose veins

LR/ GB

☐bitter taste in mouth
☐blood shot eyes
☐blurred vision
☐chest pain
☐convulsions
☐diarrhea alternating with constipation
☐difficulty swallowing
☐dry eyes
☐feeling of a lump in your throat
☐headache at the top of your head
☐hot flashes
☐muscle spasms, twitching cramping
☐numbness of hands and
☐pain in rib cage
☐red, sore or irritated eyes
☐seizures
☐skin rashes
☐tight feeling in chest
☐TMJ or locked jaw
☐you anger easily
☐you feel better after exercise

KI/BL

☐frequent urination
☐hair loss
☐joint pain
☐lack of bladder control
☐loose tooth
☐ low back pain
☐memory problems
☐night blindness or low vision
☐ringing in your ears
☐sore, cold or weak knees
☐you get up more than once to urinate at night
☐ other _____
_____
_____
_____
_____
_____

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Family History

How do you feel about the following areas of your life in the past month?

Significant other ☐ Great ☐Good ☐Fair ☐Poor ☐N/A Comments _____

Family ☐ Great ☐Good ☐Fair ☐Poor ☐N/A Comments _____

Self ☐ Great ☐Good ☐Fair ☐Poor ☐N/A Comments_____

Check illness which have occurred in any of your blood relatives:

☐Alcoholism	☐Cancer	☐Heart Disease	☐Mental Illness
☐Allergies	☐Diabetes	☐High Blood Pressure	☐Obesity
☐Bleed Easily	☐Epilepsy	☐Kidney Disease	☐Stroke

☐Other _____

Women Only

Are you pregnant? ☐NO ☐YES, How may months? _____ ☐Trying ☐Maybe

Method of birth control? _____

Age of first period _____ Date of last period _____ Age of Menopause _____

Typical length of period _____

Typical length of cycle (From the first day of one cycle to the 1st day of the next) _____

Number of pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Hysterectomy ☐ NO ☐ YES if yes was it a ☐Partial or ☐ Complete Date _____

Check all that apply to you:

☐Scanty Flow	☐Painful Periods	☐Low Libido
☐Heavy Flow	☐Breast Tenderness	☐Excessive Libido
☐Clotting	☐Breast Lumps	☐Painful Intercourse
☐Vaginal Discharge	☐Nipple Discharge	☐ Infertility
☐Abnormal Pap smear	☐Fibrocystic Breast	☐Fibroids
☐Menopausal Symptoms	☐bleeding between cycles	☐Endometriosis
☐Premenstrual problems	☐ Irregular Cycles	☐ Ovarian Cysts

☐Other _____

Men Only: Check all that apply to you

☐Low Libido	☐Seminal Emissions	☐Prostate Problems
☐Excessive Libido	☐Premature Ejaculation	☐Testicular Pain
☐Impotence	☐Painful intercourse	☐Testicular Redness
☐Vasectomy, Date _____	☐Testicular Swelling	

☐Other_____

Medications: Please list herbal supplements and vitamins along with your medications

Drug/Supplement/Vitamin	Reason for taking	For how long	Dosage	Frequency

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Lifestyle

How would you rate the following areas of your health in the past month?

Digestion ☐ Great ☐Good ☐Fair ☐Poor Comments _____

Stools ☐ Great ☐Good ☐Fair ☐Poor Comments _____

How many times per day? _____ Do you feel complete? ☐YES ☐NO

Stool consistency? ☐ Loose ☐ Formed ☐Hard to pass ☐other _____

What is the color of your stools? _____

Is there blood in your stools? ☐NO ☐YES if yes, how often _____

Urination ☐Great ☐Good ☐Fair ☐Poor Comments _____

How many times a day? ____ what color is your urine? _____ is it painful to urinate? ☐NO ☐YES

Do you get up in the middle of the night to urinate? ☐NO ☐YES if yes, how often? _____

Appetite ☐Great ☐Good ☐Fair ☐Poor Comments _____

Diet ☐Great ☐Good ☐Fair ☐Poor Comments _____

Food/ Drink

Foods you crave _____ When? _____

Daily water intake _____

Daily soda intake _____ Caffeine? ☐NO ☐YES Daily coffee intake _____ Caffeine? ☐NO ☐YES

Daily Tea intake _____ Caffeine? ☐NO ☐YES

Do you drink alcohol? ☐NO ☐YES if yes, how much _____ how often? _____

What kinds of alcohol? _____ Part use? ☐NO ☐YES date stopped _____

Do you use tobacco? ☐NO ☐YES Part use? ☐NO ☐YES date stopped _____

Do you use Marijuana? ☐NO ☐YES if yes how often? _____

Do you use recreational drugs? ☐NO ☐YES Part use? ☐NO ☐YES date stopped _____

How do you feel about the following areas of your life in the past month.

Energy ☐Great ☐Good ☐Fair ☐Poor Comments _____

On a scale of 1 to 10? (10 is high energy) _____

Sleep ☐Great ☐Good ☐Fair ☐Poor Comments _____

Hours per night? _____ Do you wake feeling rested? ☐NO ☐YES

Sex life ☐Great ☐Good ☐Fair ☐Poor Comments _____

School ☐Great ☐Good ☐Fair ☐Poor Comments _____

Exercise ☐Great ☐Good ☐Fair ☐Poor Comments _____

How often? _____ What kind? _____

How would you rate your stress level on a scale of 1 to 10? (10 is high stress) _____

How well do you feel you handle your stress? ☐Great ☐Good ☐Fair ☐Poor

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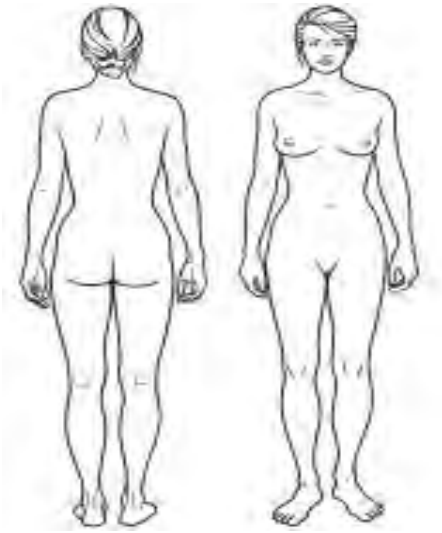
Pain

Please answer the following questions if you have pain.
Indicate on the diagram your areas of pain



Describe the onset of your pain? _____
_____
_____
_____
_____
_____

On a scale of 1-10 (10 being the worst) how strong is your pain?
_____

How long have you had this pain? _____

What does your pain feel like? (Check all that apply)
☐Dull ☐Sharp ☐Stabbing ☐Sore ☐Achy ☐Cramping ☐Burning ☐Constant ☐Comes and goes
☐Fixed ☐Moves about

Does the pain radiate? ☐NO ☐YES Where? _____

What helps the pain? ☐Ice ☐Heat ☐Rest ☐Movement ☐Pressure ☐Moisture ☐ Massage ☐Nothing
☐Other _____

What aggravates the pain? ☐Ice ☐Heat ☐Rest ☐Movement ☐Pressure ☐Moisture ☐ Massage ☐Nothing
☐Other _____

Does anything relieve this pain? (i.e.; medications, over the counter drugs, liniments) _____
_____

Oher treatments you have had for this pain? _____
_____

Anything you wish to add? _____
_____

The above information is true to the best of my knowledge.

_____ _____
Patients Signature Date