Welcome to Escondido Acupuncture Wellness!

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Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Name: ____ Date: ______/______/______

Address: ____

City, State, Zip Code: ____

Phone: Cell (_____)_____________ Home (_____)___________ Work (_____)____________

Email Address: ____

Age: _______ Date of Birth: _____/______/_____ Marital Status: ❑S ❑M ❑D ❑W ❑Partnered

Social Security Number (If needed for insurance purposes): __________-_______-__________

Occupation:____________________________ Employer:__________________________________

Name of Emergency Contact _____________________________ Relationship ________________

Phone of Emergency Contact (______)____

Name of Primary Physician ____

Phone of Primary Physician (______)____________________ May I contact them?____________

Who can we thank for having referred you? Friend/Referral ______________________________

❑Chamber of Commerce ❑BNI ❑ Acufinder ❑ Yelp ❑ HealthProfs ❑ My website

❑ Google ❑Wellness.com ❑ Medical Doctor ❑ Other website __________________

Major Complaint(s), in order of significance to you:

____

____

____

My concerns are a result of: ❑ Auto Accident ❑ Job Related ❑ Injury ❑ Other______________

How do these conditions impair your daily activities?

____

II. Patient Medical History

How was your childhood health (physically, emotionally)?

____

Recent tests: (please indicate test results and date below)

❑Physical ❑Cholesterol ❑Prostate ❑Blood (which?) __________________

❑HIV/STD ❑Pap smear ❑Mammography ❑Other: ________________________

Test Results and Date: ____

Check any you have had in the past or present:

❑Diabetes	❑Allergies	❑Glaucoma	❑Rheumatic Fever
❑Heart Disease	❑CVA (stroke)	❑Vein condition	❑Thyroid disorder
❑Asthma	❑Pneumonia	❑Tuberculosis	❑Emphysema
❑Jaundice	❑Gonorrhea	❑Mumps	❑Bleeding tendency
❑Syphilis	❑Measles	❑Chicken pox	❑Nervous disorder
❑Meningitis	❑HIV	❑Polio	❑Mononucleosis
❑Epilepsy	❑High fever	❑Hepatitis	❑Multiple Sclerosis
❑Paralysis	❑Cancer	❑Migraines	❑High blood pressure

Other: ____

Immunizations: ____

Surgeries (Please list all surgeries, necessary and voluntary with their dates):

____

____

____

____

Scars (small or large) not related to surgeries:

____

____

Current medications/Herbs/Supplements are:

____

____

____

____

III. Patient Profile

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

❑Cold hands ❑Cold fingers ❑Cold feet ❑Cold toes
❑Sweaty hands ❑Sweaty feet ❑Afternoon flushes ❑Night sweats
❑Heat in the hands, feet, and chest ❑Hot flashes any time of the day
❑Thirsty ❑Perspire easily ❑Lack of perspiration
❑Take water to bed

Overall energy (Lung, Kidney function):

❑Shortness of breath ❑Low energy ❑General weakness
❑Easily catch colds ❑Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):

❑Dizziness ❑See floating black spots ❑ Overall cold sensation

Heart function:

❑Palpitations ❑Anxiety ❑Sores on the tongue
❑Restlessness ❑Mental confusion ❑Chest pain traveling to shoulder
❑Frequent dreams ❑Wake tired ❑Drink coffee (# of cups per week: ___)

Lung function:

❑Nasal Discharge (Color: ___________________________) ❑Cough
❑Nose Bleeds ❑Sinus Congestion ❑Dry mouth ❑Sore throat
❑Dry Nose ❑Dry Skin ❑Allergies (To what? __________________)
❑Sneezing ❑Overall achy feeling in the body
❑Difficulty breathing ❑Smoke cigarettes (# of cigarettes per day: ____________)
❑Sadness ❑Melancholy

Spleen function:

❑Low appetite ❑Abrupt weight gain ❑Abrupt weight loss
❑Abdominal bloating ❑Abdominal gas ❑Fatigue after eating
❑Prolapsed organs (previously diagnosed, which organ? __________________________)
❑Easily bruised ❑Hemorrhoids ❑Worry/Over-thinking

Spleen, Stomach, Large Intestine, Small Intestine function:

❑Loose stools ❑Constipated ❑Incomplete stools ❑Diarrhea
❑Blood in stools ❑Mucous in stools ❑Undigested food in stools

Dampness trapped in the body:

❑General sensation of heaviness ❑Mental fogginess ❑Swollen hands
❑Swollen feet ❑Swollen joints ❑Chest congestion ❑Nausea

Stomach function:

❑Burning sensation after eating ❑Large appetite ❑Bad breath
❑Mouth (canker) sores ❑Bleeding, swollen or painful gums
❑Heartburn ❑Acid regurgitation ❑Ulcer (diagnosed) ❑Belching
❑Hiccoughs ❑Stomach pain ❑Vomiting

Liver, Gall Bladder function:

❑Alternating diarrhea and constipation ❑Chest pain
❑Tight sensation in the chest ❑Bitter taste in the mouth
❑Anger easily ❑Frustration ❑Depression ❑Irritability
❑Frequently unable to adapt to stress (What causes the stress? ____________________)
❑Skin rashes ❑Headache at the top of the head ❑Numbness
❑Tingling sensation ❑Muscle spasms ❑Muscle twitching ❑Muscle cramping
❑Seizures ❑Convulsions ❑Lump in the throat ❑Neck tension
❑Limited Range-of-Motion, Neck ❑Shoulder tension
❑Limited Range-of-Motion, Shoulder ❑Drink alcohol
❑Recreational drugs (Which? ______________________, How much per week? _________)
❑High-pitched ringing in the ears ❑Gall stones (history or current)

Eyes (Liver function):

❑Itchy ❑Bloodshot ❑Burning ❑Dry
❑Watery ❑Gritty ❑Blurry vision ❑Decreased night vision
❑Near-sighted ❑Far-sighted

Kidney, Urinary Bladder function:

❑Frequent cavities ❑Easily broken bones ❑Sore knees
❑Weak knees ❑Cold sensation in the knees ❑Low back pain
❑Memory problems ❑Excessive hair loss ❑Easily startled
❑Kidney stones ❑Bladder infections ❑Urinating twice or more during the night
❑Lack of bladder control ❑Fear ❑Low-pitched ringing in the ears

Urination:

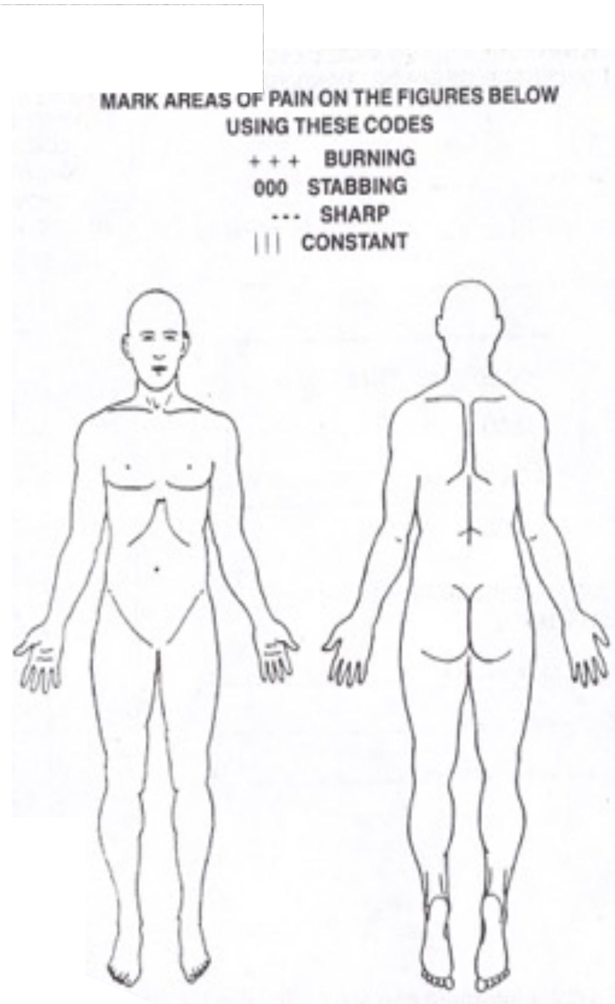
❑Normal color ❑Dark yellow ❑Clear ❑Reddish
❑Cloudy ❑Scanty ❑Profuse ❑Strong odor
❑Burning ❑Painful ❑Discharge ❑Difficult
❑Urgent ❑Frequent

Libido:

❑Normal ❑High ❑Low

For Pain Complaints:

Please mark areas of your body where you have pain on the image below:



The pain feels:

❑Sharp ❑Burning ❑Aching

❑Cramping ❑Dull ❑Moving

❑Fixed ❑Other:_______________

The pain feels better with:

❑Pressure ❑Cold ❑Heat
❑Rest ❑Exercise
❑Other:_________________________________

The pain feels worse with:

❑Pressure ❑Cold ❑Heat
❑Rest ❑Exercise
❑Other:_________________________________

The pain is worse with these movements:

❑ Bending forward or backward
❑ Rotation to the left or right
❑ Stopping, weight bearing, grasping with a straight arm, holding the position with a straight arm or leg
❑ Bringing in your arms, hands, feet or knees
❑ Rotation with a bent limb
❑ Constant pain, with or without movement, paralysis

Men only:

❑Swollen testes ❑Testicular pain ❑Erectile Dysfunction ❑Premature ejaculation
❑Prostate problems ❑Other_________________________________

***Women only*: Please fill in the following information even if you are no longer menstruating.**

Monthly menstrual cycle? ❑Y ❑N Currently Pregnant? ❑Y ❑N ❑Possibly
Number of pregnancies:________________ Number of miscarriages:_________________
Number of abortions: __________________ Number of children:_____________________
Age of first menstrual cycle:_____________ Age of menopause (if applicable):__________
Average number of days of flow:_________
Average number of days of entire cycle (first day of flow to next first day of flow):________
❑Form of Contraception ____

❑Bleeding between periods ❑Hormone Replacement
❑Abnormal Pap Smear ❑Vaginal Infections
❑Endometriosis ❑Uterine Fibroids
❑Full Hysterectomy ❑Partial Hysterectomy (still have ovaries)

Do/Did you experience any of the following pre-menstrual syndromes?

❑Nausea ❑Vomiting ❑Water retention ❑Breast swelling/tenderness
❑Food cravings ❑Headaches ❑Migraines ❑Hot at night
❑Depression ❑Irritability ❑Anxiety ❑Constipation
Emotions:____
❑Dull pain, where?____________________ ❑Sharp pain, where?______________________

Do/Did you experience any of the following with your menstrual flow?
❑Cramps ❑Clots ❑Heavy blood flow ❑Minimal blood flow
❑Tiredness ❑Loss of Appetite ❑Diarrhea ❑Headaches
❑Dizziness ❑Depression

For everyone:

I accept my responsibility to provide a 24-hour appointment cancellation notice. Your missed appointment fee without 24 hours notice is $100.

Patient Signature:____ Date _____________________

Acupuncturist Signature:____________________________________ Date _____________________