INTEGRATIVE HEALING ARTS

ACUPUNCTURE • HERBAL MEDICINE • MASSAGE THERAPY

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?____

____

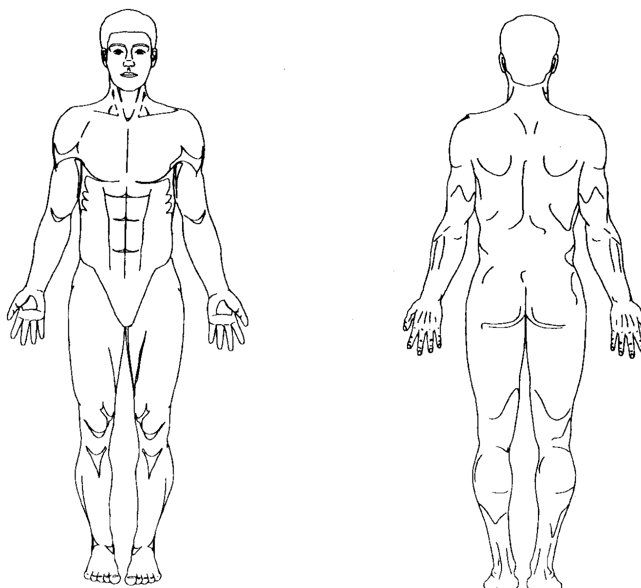
Are you taking any medication? Please note all medication, herbs, vitamins and minerals you take even if you take them only occasionally.____

____

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.



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www.integrativehealingarts.com
(917)-294-3805

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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.

____

____

____

____

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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? ____

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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: ____

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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: ____