Whole Health
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ACUPUNCTURE | MASSAGE THERAPY | ENERGY MEDICINE

Today's Date _____/_____/_____

(Please Print)

Name: _____
Address:_____
City, State, Zip: _____
Home Phone: _____ Work Phone: _____
Date of Birth: _____ Sex (F) (M) Age: ____ Email: _____
Weight _____lb. Occupation:_____
Referral source:_____
Reason for visit today: _____
_____
Have you had acupuncture before? Yes___ No___ Chinese herbal medicine? Yes___ No___
Have you had professional massage before? Yes___ No___
How long have you had this condition?
Is it getting worse? Does it bother your: ___sleep ___work ____other (what?)
What seemed to be the initial cause?
What seems to make it better?
What seems to make it worse?
Are you under the care of a physician now? ___Yes ___No If yes, for what?
Who is your physician? Physician's phone:
Other concurrent therapies?

Family Medical History

Allergies	Arteriosclerosis	Cancer	Diabetes	Seizures
Asthma	Alcoholism	Heart Disease	High Blood Pressure	Stroke

Your Past Medical History

(check any of the following conditions you currently have, or have had in the past **C**=**current**, **P**=**past**)

__AIDS/HIV	__Diabetes	__Multiple Sclerosis	__Tuberculosis
__Alcoholism	__Emphysema	__Mumps	__Typhoid Fever
__Allergies	__Epilepsy	__Pacemaker	__Ulcers
__Appendicitis	__Goiter	__Pleurisy	__Venereal Disease
__Arteriosclerosis	__Gout	__Pneumonia	__Thyroid Disorders
__Whooping Cough	__Asthma	__Heart Disease	__Polio
__Major Trauma	__Birth Trauma	__Hepatitis	__Rheumatic Fever
__Herpes	__Scarlet Fever	__Cancer	__High Blood Pressure
__Seizures	__Chicken Pox	__Measles	__Stroke

__Other (specify, car, fall, etc.)

Have you had all your childhood immunizations? ____Yes ____No

Major Surgeries/Hospitalizations

	Year	Operation/Illness
1st		
2nd		
3rd		

Medicines: Please list all prescription medications you are currently taking:

_____

_____

Vitamins/Supplements:

_____

Your Diet (Please circle all that apply)

Appetite	Coffee (cups per day_____)	Sugar	Water Intake:
*Low	Soft Drinks		# glasses per day: _____
*High			

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack	Evening
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Habits

Tobacco:

Cigarettes: how many per day _____

Chewing: times per day _____

Marijuana: Use per day _____

Alcohol: Number of drinks per week _____

Please tell me about your childhood (including family relationships), young adulthood and your adult life (including spousal/family relationships):

HEAD AND NECK
- ❑ Dizziness
- ❑ Fainting
- ❑ Neck stiffness
- ❑ Enlarged lymph glands
- ❑ Headaches
- ❑ Other

EYES
- ❑ Blurred vision
- ❑ Visual changes
- ❑ Poor night vision
- ❑ Spots
- ❑ Eye inflammation
- ❑ Dry eyes
- ❑ Itchy eyes
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Other

EARS
- ❑ Infection
- ❑ Discharge
- ❑ Ringing
- ❑ Decreased hearing
- ❑ Other

NOSE, THROAT & MOUTH
- ❑ Bleeding
- ❑ Sinus infection
- ❑ Hay fever or allergies
- ❑ Excessive phlegm
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Oral ulcers
- ❑ Grinding teeth
- ❑ TMJ
- ❑ Sores on lips or tongue
- ❑ Other

RESPIRATORY
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ Coughing up phlegm
- ❑ Difficulty breathing
- ❑ Wheezing/asthma
- ❑ Frequent colds
- ❑ Other

CARDIO-VASCULAR
- ❑ High blood pressure
- ❑ Blood clots
- ❑ Palpitations
- ❑ Chest pain or tightness
- ❑ Rapid heart beat
- ❑ Irregular heart beat
- ❑ Poor circulation
- ❑ Swelling of ankles
- ❑ Other

SKIN
- ❑ Hives
- ❑ Rashes
- ❑ Eczema
- ❑ Night sweating
- ❑ Excess sweating
- ❑ Dryness
- ❑ Bruise easily
- ❑ Changes in moles or lumps
- ❑ Other

MUSCLE AND JOINT
- ❑ Joint disorder
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Difficulty walking
- ❑ Spinal curvature
- ❑ Backache
- ❑ Back pain
- ❑ Other

NEUROLOGICAL
- ❑ Seizures
- ❑ Tremors
- ❑ Numbness or tingling of limbs
- ❑ Pain paralysis
- ❑ Other

GENERAL
- ❑ Insomnia
- ❑ Frequent dreams/nightmares
- ❑ Depression
- ❑ Agitation
- ❑ Fatigue
- ❑ Aversion to cold
- ❑ Frequent urination
- ❑ Irritability
- ❑ Thirst
- ❑ History of psychiatric treatment
- ❑ Other

GASTROINTESTINAL
- ❑ Nausea
- ❑ Indigestion
- ❑ Stomach pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Vomiting blood
- ❑ Blood in stool or black stools
- ❑ Hemorrhoids
- ❑ Gallbladder disorder
- ❑ Recent change in weight
- ❑ Food cravings
- ❑ Other

GENITO-URINARY
- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Unable to hold urine
- ❑ Incomplete urination
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stone
- ❑ Other

MALE
- ❑ Pain/itching of genitals
- ❑ Genital lesions/discharge
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Lumps in testicles
- ❑ Other

FEMALE ❑ Frequent urinary tract infections ❑ Frequent vaginal infections ❑ Pain/itching of genitalia ❑ Genital lesions/discharge ❑ Pelvic inflammatory disease ❑ Abnormal pap smear ❑ Abnormal bleeding ❑ Menopausal symptoms ❑ Breast lumps ❑ Age menses began _____ ❑ Length of cycle (day 1 to day 1) _____ ❑ Duration of flow _____ ❑ Irregular periods ❑ Painful periods ❑ PMS ❑ Vaginal discharge (color) _____ ❑ Vaginal sores ❑ Vaginal odor ❑ Clots ❑ # of pregnancies ❑ # live births ❑ Premature births ❑ Age at menopause ❑ Date of last PAP _____ ❑ Date last period began _____ ❑ Other		