Jennifer Rose Acupuncture

NAME________________________________ DATE__________________________

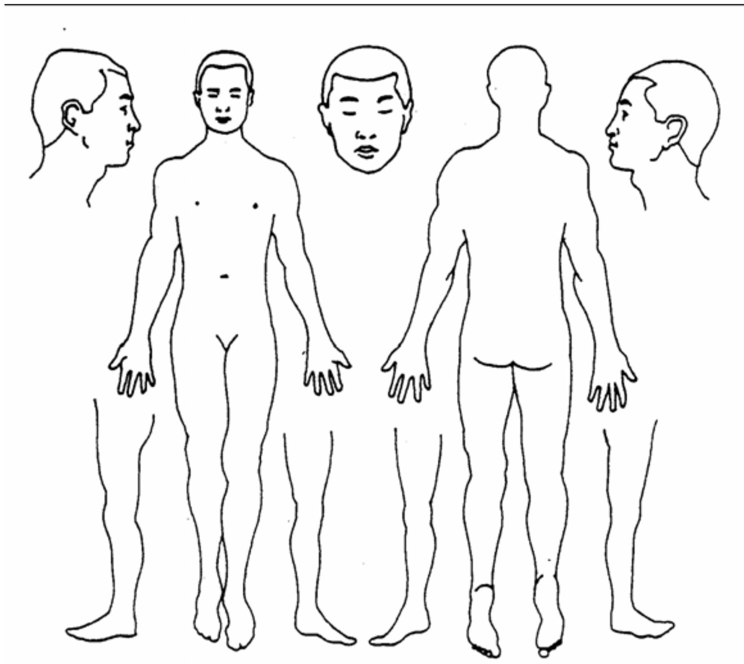
I. Goals: What would you most like to achieve through your work with Traditional Chinese Medicine?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X	Sharp/stabbing
P P P	Pins & Needles
D D D	Dull/Aching N
N N	Numbness

For Women:

1. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

2. Indicate number of occurrences:

Live Births _______ Pregnancies_______ Miscarriages _______ Abortions _______

3. Age: First period _____ Menopause (if applicable) _____

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / ______

5. Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? __________________________

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6. Is your menses cycle regular? [ ] Yes [ ] No
a) Average number of days of flow _______
b) The flow is: [ ] Normal [ ] Heavy [ ] Light
c) The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

7. Do you have the following menstruation related signs/symptoms?
[ ] Difficulty with Orgasm [ ] Cramps [ ] PMS [ ] Heavy Vaginal discharge between periods
[ ] Pain with Intercourse [ ] Nausea [ ] Bleeding between Periods
[ ] Blood Clots [ ] Breast Distention [ ] Vaginal Discharge

For Men:

1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe:____

2. Check all that apply:

[ ] Erectile dysfunction [ ] Difficulty with orgasm [ ] Pain or swelling of the testicles [ ] Frequent need to urinate at night
[ ] Impotence/erectile dysfunction [ ] Premature ejaculation [ ] Feeling of coldness or numbness in genitalia
[ ] Pain/Subtly of testicles

3. Do you get up at night to urinate? [ ] Yes [ ] No How often? ______________________________

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?
____

5. Have you sought Medical intervention for these problems? If so, when? ______________________
____

6. What treatments have you tried for these problems and how successful have they been?
____

III. Medical History

Please check all that apply	Date Diagnosed		Date Diagnosed
Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	Auto Immune Condition	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

IV. Surgical History

____ Date ______________
____ Date ______________
____ Date ______________

Do you have any type of cosmetic implants? Yes ____ No ____
Do you have a pacemaker? Yes ____ No ____

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V. Family History

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________

Do you take Coumadin/Warfarin? Yes ____ No ____

Allergies (to medications, chemicals or foods):

_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________
_______________ _______________ _______________

VIII. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet?
(ie Vegetarian, Vegan, Low Carb, etc.)

____

2. What do you eat on a "typical" day? ______________________________
a) Breakfast ______________________________
b) Lunch ______________________________
c) Dinner ______________________________
d) Snacks ______________________________
e) Foods you tend to crave: ______________________________

f) Foods you dislike: ______________________________

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IX. Social History

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks: ______

b) Alcohol: ______

c) Cigarettes, cigars, other tobacco: ______

d) Other drugs: ______

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?

______

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms?

______

______

7. In the past year, how many days have been significantly affected by your health? ______

8. How many days did you feel generally poor? ______

9. How many times were you in the hospital? ______

10. Please describe your current exercise regimen:

Hours per week: ______ Activities: ______ [ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? ______

12. Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

13. Who would you describe as your source of primary social support? (relationship to you)

X. Other Information

Please list and briefly describe the most significant events in your life:

1. ______
2. ______
3. ______
4. ______

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

______

______

______

______

______

______

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HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: ______________

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HECK & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: ______________

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: ______________

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: ______________

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heartbeat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: ______________

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: ______________

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: ______________

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: ______________

MALE

Past	Current	Condition
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: ______________

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: ______________

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: ______________

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: ______________

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain

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