



Healing Perspective Acupuncture

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www.HealingPerspective.com

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Note: Information provided on this form is confidential

It is very important the information given are complete and accurate to assist you properly in your healing process.

Please PRINT Today's Date ___/___/___ Email: _____

How did you hear about us? (PLEASE CHECK ONE)

friend ___ relative ___ newspaper ___ website ___ healthcare referral ___

Name _____ Date of Birth ___/___/___ Age: ___ Sex: Male Female

Address _____

City/ State/ Zip _____

Telephone(home) _____ (work) _____ Occupation _____

Emergency Contact Person / Relationship _____ Tel: _____

Physician _____ Physician's phone # _____

What do want treated with acupuncture? _____

How long have you had this condition? _____ The onset was: sudden ___ gradual ___

Symptoms relieved by _____ Symptoms worsened by _____

What medical diagnosis have you received for this condition? _____

What other treatments have you received for this condition? _____

What medications are you taking? _____

For what condition(s)? _____

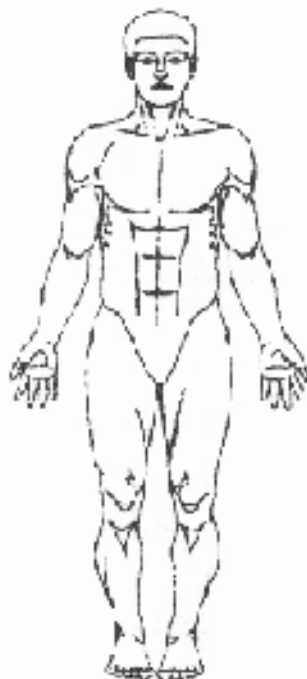
Is this your first experience in Oriental Medicine and acupuncture? _____

How do you feel about acupuncture? _____

Are you currently pregnant? Yes No

Are you presently trying to get pregnant? Yes No

On the following drawings, shade in the areas where you feel should be addressed.



Past Medical History:

Have you had any of this condition(s)? Check all that apply:

- | | | |
|-------------------------|---------------------|--------------------|
| AIDS/HIV | Fibromyalgia | Polio |
| Alcoholism | Heart Disease | Rheumatic Fever |
| Allergies (food, latex) | Hepatitis A/B/C | Scarlet Fever |
| Asthma | Herpes | Seasonal Allergies |
| Birth Trauma | Joint Replacements | Seizures |
| Cancer | Lyme's Disease | Sinus Infections |
| Diabetes | Lymph Nodes removed | Tuberculosis |
| Drug Addictions | Multiple Sclerosis | Operations_____ |
| Emphysema | Pacemaker | Other_____ |

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother: _____
 Father: _____
 Siblings: _____
 Grandparents: _____

Exercise & Energy:

How is your energy? _____
 What time of day is your energy: Highest? _____ Lowest? _____
 Do you fatigue easily? _____
 What kind of exercise do you do? _____
 How often do you exercise? _____

Emotions & 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
 Are you in a relationship? Yes No
 How do you feel about your relationship? _____
 How do you hold stress? _____
 How do you relax? _____
 How do you feel about your work? _____
 How long do you normally sleep? _____ hours per night
 I have difficulties with (check all that apply): Falling asleep Staying asleep Dream-disturbed sleep
 Waking up at about _____ am/pm and not being able to fall asleep again

Gastrointestinal:

I have (check all that apply): Belching Nausea Vomiting Vomiting of blood Ulcers Bloating
 Acid regurgitation Heartburn Hernia Indigestion Severe stomach pain
 Bowel movements: How often? _____ time(s)/day _____ days/week
 I have (check all that apply): Irregular Constipation Diarrhea Gas Burning sensation Hemorrhoids
 Undigested food in stool Loose stool Hard stool Blood in stool Itchiness Painful bowel movements

Urinary:

Urination: How often? _____ times per day Color: Pale yellow Dark yellow/orange
 I have or had (check all that apply): Trouble starting stream Frequent urination Incontinence Pain
 Burning Dribbling when sneezing Blood in urine Kidney stones Urinary tract infections
 Other _____

Women:

At what age did you start menstruating? _____ Number of days between cycles: _____

Number of days of flow: _____ Color: _____

I have or 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? No Yes Color _____

Men:

I have (check all that apply): Prostatitis Impotence Penis blood/mucous discharge

Other: _____

Muscles, Joints & Bones:

Do you have pain or tightness? No Yes Where? _____

The pain is (check all that apply): Sharp Dull Aching Numb Superficial Pain Deep Pain

Burning Tingling Shooting Pain worse/better with heat Pain worse/better with cold

Pain worse/better with pressure Pain worse in am/pm

I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis Bone pain Muscle cramping

Muscle pain Repetitive Strain Injury Fractured Bone(s) Where? _____

Other _____

Eyes, Ears, Nose, Throat, & Head:

Do you smoke? No Yes _____ per day, for _____ years

I have (check all that apply): Frequent colds Chronic runny nose Frequent sore throat Chronic cough

Coughing blood Cough up mucous Pain inhaling Shortness of breath on exertion/at rest Asthma

Nose bleeds Painful/red eyes Poor vision See spots/floaters Dizziness Cold sores

Bleeding gums Dry mouth Ear pain Ringing in ears Clogged/popping in ears

Frequent headaches/migraines describe: _____

Cardiovascular:

I have (check all that apply): Chest pain Palpitation Varicose veins Phlebitis Cold hands and feet

Irregular heart beat Poor circulation Other: _____

Skin & Hair:

I have or often have (check all that apply): Dry skin Skin rashes Itching Acne Eczema Hives

Hair loss Premature graying Other: _____