Welcome to Ancient Spring Acupuncture Clinic

Please take a moment to provide some information about yourself and your health conditions, so that we may do our best to treat you. Ancient Spring Acupuncture Clinic considers this information privileged physician/ patient communication and withholds it in confidence. If you have any question, please don't hesitate to ask for assistance. **Please Print**

Personal Information

Name: _____ Birth Date: _____

Address: _____

City _____ State _____ Zip _____

Phone _____ Email _____

How were you referred? _____

Emergency Contact

In case of emergency, who should be notified? _____

Relationship: _____ Phone: _____

Current Health Status

Have you received acupuncture before? Yes No

Primary concern: _____

How long has it persisted? _____

Treatment received: _____

Your medical doctor's name _____ Phone: _____

Diagnosis of your condition: _____

Secondary concerns: _____

Daily Activity

Work: _____

Recreation: _____

Exercise: _____

Are there any activities that affect your condition?: _____

Explain: _____

How do you reduce stress?: _____

Do you smoke/drink?: _____

Medications

Current Medications: _____

Vitamins/Supplements: _____

Please continue to Page 2

ANCIENT SPRING ACUPUNCTURE

HEALTH HISTORY

(Confidential)

Name: Today's Date:

Please check symptoms you currently have or have experienced in the past year.

General
- □ Chills
- □ Dizziness
- □ Fatigue
- □ Fevers
- □ Forgetfulness
- □ Headache
- □ Insomnia
- □ Nervousness
- □ Numbness
- □ Sweats
- □ Weight Gain
- □ Weight Loss

Cardio-Respiratory
- □ Asthma
- □ Chest Pain
- □ Coughing Blood
- □ High Blood Pressure
- □ Irregular Heart Beat
- □ Low Blood Pressure
- □ Night Sweats
- □ Persistent Cough
- □ Phlegm Production
- □ Poor Circulation
- □ Recurrent Bronchitis
- □ Shortness of Breath
- □ Swelling of Ankles
- □ Varicose Veins

Skin
- □ Blood not Clotting
- □ Bruise Easily
- □ Discoloration
- □ Lumps in Groin
- □ Lumps Underarm
- □ Skin Problem

Gastrointestinal
- □ Abdominal Pain
- □ Black Stools
- □ Bloating
- □ Blood in Stools
- □ Constipation
- □ Diarrhea
- □ Difficulty Swallowing
- □ Gas
- □ Heartburn /Reflux
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Poor Appetite
- □ Stomach Pain
- □ Vomiting
- □ Vomiting Blood

Genitourinary
- □ Abnormal Urine Color
- □ Blood or Pus in Urine
- □ Burning Urination
- □ Frequent Urination
- □ Kidney Stone
- □ Poor Bladder Control
- □ Urgency to Urinate

Eye, Ear, Nose, Mouth, Throat
- □ Blurred Vision
- □ Bleeding Gums
- □ Cataract
- □ Double Vision
- □ Earache
- □ Eye Pain/Strain
- □ Floaters in Vision
- □ Glasses
- □ Hay Fever
- □ Hearing Loss
- □ Hoarseness
- □ Nosebleeds
- □ Olfactory Problems
- □ Recurrent Sore Throat
- □ Red/Inflamed Eye
- □ Ringing in Ears
- □ Sinus Problems
- □ Sores on Lips/Tongue
- □ Taste Problems
- □ Vision of Halos

Musculoskeletal

(Pain, weakness, or numbness)
- □ Arms □ Joints
- □ Back □ Legs
- □ Feet □ Muscles
- □ Hands □ Neck
- □ Hips □ Shoulders

Men Only
- □ Breast Lump
- □ Genital Pain
- □ Impotence
- □ Lump in Testicles
- □ Penile Discharge

Women Only
- □ Abnormal Papsmear
- □ Bleeding Between Periods
- □ Breast Lump
- □ Contraceptives
- □ Irregular Periods
- □ Menopause Status
- □ Painful Periods
- □ Sores on Genitals
- □ Vaginal Discharge
- □ Pregnancies
- □ Miscarriages
- □ Children Born
- □ Abortions
- □ Last Menses
- □ Last Papsmear
- □ Mammogram
- □ Are you Pregnant?

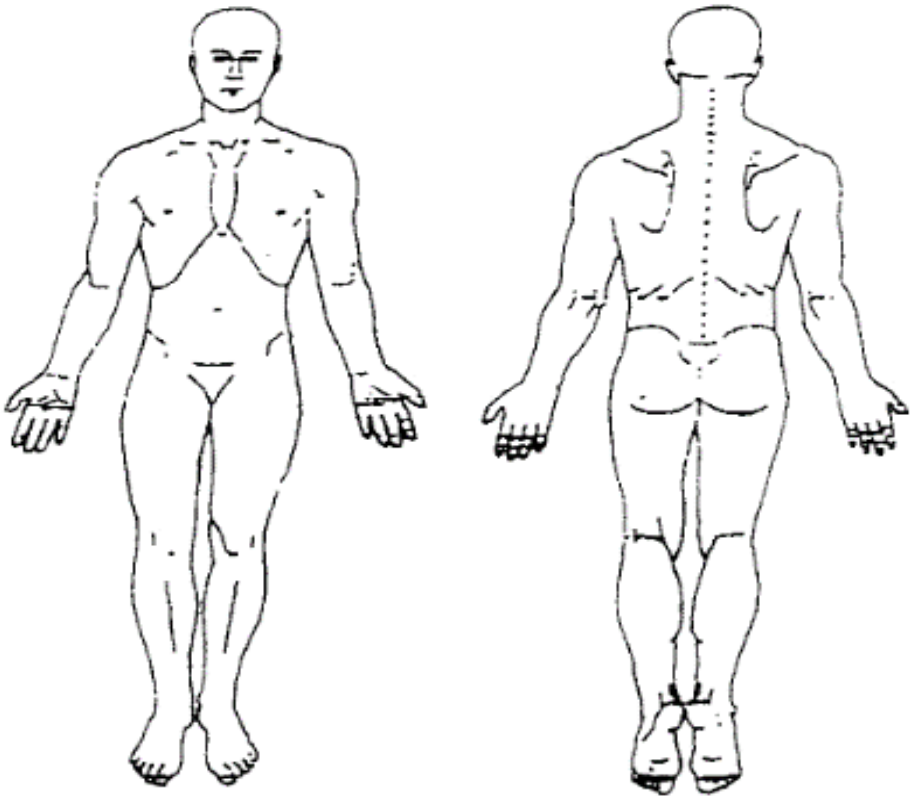
Please list any other hospitalizations, accidents, surgeries and/or major illnesses, with dates and treatments: _____

ANCIENT SPRING ACUPUNCTURE

Name: _____ Date: _____

PAIN EVALUATION

///-STABBING	XXX-BURNING	000-PINS AND NEEDLES	###-NUMBNESS



PAIN SCALE
SEVERE PAIN : 10/10
NO PAIN : 0/10

1-PLEASE REFER TO THE GRAPHIC FOR PAIN AREAS
2-MARK THE AREAS ACCORDING TO TYPE OF PAIN GIVEN IN FRAPHICS
3-FOR EACH PAIN AREA USE A "FRACTION SCALE" FOR INTENSITY:
Slight Pain= 2-3/10 Modarate Pain= 5-7/10

* I have listed all my known medical conditions and physical limitations and will inform the acupuncturist of any change in my physical/mental/emotional health. I understand my acupuncturist must be aware of any and all existing conditions in order to effectively and safely treat me. I am responsible for consulting a qualified primary healthcare provider for any ailment I may have.

Patient Signature: _____ Date: _____