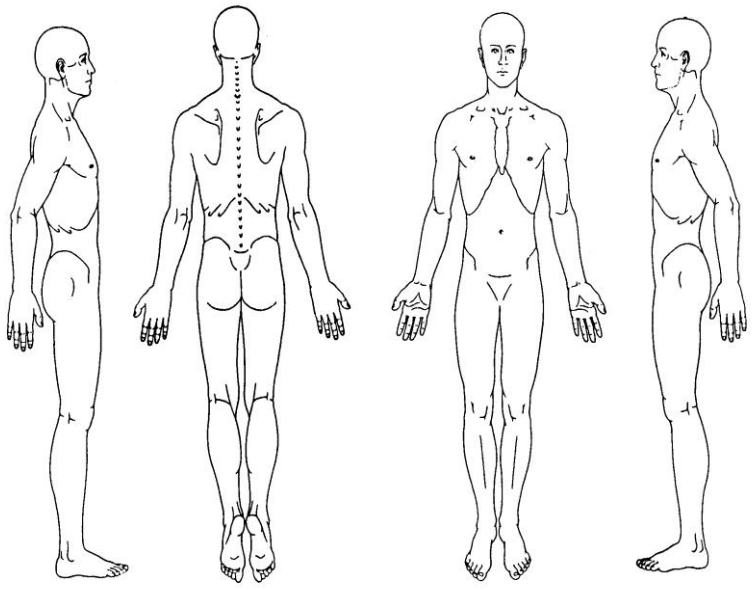
M.S. Acupuncture Clinic

MEDICAL CHART

Name: _____ Date: _____ / _____ / _____

Height: _____ Weight: _____ Blood pressure: _____/_____

Chief Complaints (What are the chief complaints you would like us to help you with?)



Mark Pain Areas

How long have you had this particular problem? (Be specific)?

What other forms of treatment have you sought?

Are you taking any medications? If yes, Please list all:

_____

- Pain began: ☐ Gradually ☐ Suddenly ☐ Don't know
- Is your pain worse when you: ☐ Sit ☐ Bend ☐ Walk ☐ Run ☐ Exercise ☐ Lift ☐ Push ☐ Pull ☐ Rest ☐ Other: _____
- Is the pain: ☐ Burning ☐ Stabbing ☐ Sharp ☐ Dull/Achy ☐ Numb ☐ Constant
- Which of the following areas do you have pain, discomfort, or restriction of motion: ☐ Neck ☐ Shoulder☐ Arm ☐ Hands ☐ Wrist ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Pelvis ☐ Hip ☐ Legs ☐ Knees ☐ Feet ☐ Ankles Other: _____
- Does your Pain travel: ☐ Yes ☐ No If yes, describe: _____
- When is the pain worst: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night
- Does your pain interfere with your: ☐ Work ☐ Sleep ☐ Daily routine
- How would you rate your pain on a scale 1 to 10, with 10 being the most extreme: 1 2 3 4 5 6 7 8 9 10

HEALTH CONDITIONS

・Surgeries: _____

・Traumas: (Auto accident / fall / other:) _____

・Allergies: (Drugs / Chemicals / Food/ Other:)_____

Please check all that apply to you.

☐ Allergies	☐ Anxiety	☐ AIDS/HIV	☐ Arthritis
☐ Asthma	☐ Back pain	☐ Blurred vision	☐ Breathing difficulties
☐ Cancer	☐ Carpal tunnel syndrome	☐ Chest pain	☐ Chronic fatigue
☐ Constipation	☐ Depression	☐ Diabetes	☐ Diarrhea
☐ Difficult concentration	☐ Digestion problems	☐ Dizziness	☐ Fibromyalgia
☐ Frequent urination	☐ Feeling cold	☐ Feeling hot	☐ Foot pain
☐ Gastrointestinal disorder	☐ Gout	☐ Glaucoma	☐ Hepatitis
☐ High blood pressure	☐ Headache	☐ Heart problems	☐ Hives
☐ Insomnia	☐ Irritable bowel syndrome	☐ Immune deficiency	☐ Itchiness
☐ Lupus	☐ Lyme's disease	☐ Menstrual disorder	☐ Neck pain
☐ Numbness & tingling	Palpitation (heart)	☐ Poor appetite	☐ Persistent cough
☐ Sciatica	☐ Shoulder pain	☐ Spinal misalignment	☐ Spinal fusion
☐ Skin problem	☐ Stress	☐ Tendonitis	☐ T.M.J
Other (please specify)			

Briefly describe Family History:

・Mother's side: _____

・Father's side: _____

Women Only:

・Age of first period: ____・Date of last period: _____・Menstruation: ☐ Normal ☐ Irregular ☐ Painful
・Amount: ☐ Normal ☐ Excessive ☐ Little
・Color: ☐ Normal ☐ Dark ☐ Bright ☐ Clots
・Cramping: ☐ Yes ☐ No ☐ Mild ☐ Moderate ☐ Severe
・Discharge: ☐ Yes ☐ No ・ Between periods: ☐ Yes☐ No
・Color: ☐ Normal ☐ Dark ☐ Bright ☐ Clots ・PMS: ☐ Yes ☐ No
・History of Pregnancy:
Pregnancies Number: ___ Births: ___ Miscarriages: ___ C-Section: ___ Premature births: ___ Abortions: ___
・Hysterectomy: Year: _____ Hot Flashes: __ If yes, how many? ___ Night Sweats: __ If yes, how many?___

Nutrition and Lifestyle:

・How is your appetite? _____ Do you have regular eating habits? ☐ Yes ☐ No If no, _____times a day
・Do you crave certain foods? ☐ Yes: ___ ☐ No: ___ If yes, what foods do you crave? _____
・Do you smoke? ☐ Yes ☐ No ・Do you drink? ☐ Yes ☐ No ・How often _____, how many glasses _____
・Do you exercise regularly? ☐ Yes ☐ No If yes, What exercises do you do regularly? _____
・Do you sleep well? Yes ☐ No ☐ Do you get enough sleep at night? ☐ Yes ☐ No
・How many hours do you sleep at night? _____
・How often do you wake up during the night? _____ ・The reason for waking _____
・Describe the quality of sleep you get _____
・Are you under a lot of stress? ☐ Yes ☐ No ・Work related? ☐ Yes ☐ No
・How do you manage your stress? _____
・Do you get angry easily? ☐ Yes ☐ No Do you cry easily? ☐ Yes ☐ No
・Do you ever feel a lump in your throat? ☐ Yes ☐ No ・Do you have lots of phlegm? ☐ Yes ☐ No
・How is your digestion? ☐ Good ☐ Bad ☐ Heartburn☐ Acid reflux ☐ Cramping ☐ Bloating ☐ Stomach gas
・How is your urination? ☐ Normal ☐ Frequent ☐ Burning sensation ・Color: ☐ Clear ☐ Yellow

・How are your bowel movements? ☐ Normal ☐ Constipated ☐ Diarrhea ・Stool: ☐ Firm ☐ Loose
☐ Abdominal gas ☐ Abdominal cramping
・Do you feel thirsty? ☐ Yes ☐ No Dry mouth: ☐ Yes ☐ No Bitter taste: ☐ Yes ☐ No
・Do you drink lots of water? ☐ Yes ☐ No If yes, why? ☐ Thirsty ☐ Habit ☐ For health
・Do you have feelings of nausea? ☐ Yes ☐ No Do you vomit often? ☐ Yes ☐ No
・Do you have headaches? ☐ Yes ☐ No If yes, where? ☐ Forehead ☐ Sides ☐ Back ☐ Top ☐ Whole
・How is your energy level? ☐ High ☐ Medium ☐ Low

Do not write below this line:

(OFFICE USE ONLY)

Pulse:	Tongue:
Diagnosis:	
Treatment Principle:	
Acupuncture Points:	
Recommendation / Comments:	
Notes:	