Tallahassee Chinese Medicine / Tallahassee Community Acupuncture

Patient Name: _____ Date: _____
Address: _____
City/State/Zip: _____ Occupation: _____
Home #: _____ Work #: _____ Email: _____
Birthdate: _____ Marital Status: _____ Age: _____ M / F
Emergency Contact: _____ Referred by: _____

Reason for visit: 1/ _____
2/ _____
3/ _____

How long have you had this condition? _____ Getting worse? Y / N
Does it bother you during: 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? Y / N How long? _____
Who is your physician? _____ Phone: _____
Current medications: _____
Current supplements: _____

Family Medical History:(Grandparents, Mother, Father, Siblings)

__Allergies:(list) _____
__Arteriosclerosis __Diabetes __Heart Disease __Obesity __Stroke __Arthritis
__Asthma __Cancer __Addiction __Seizures __Ulcers __Other _____

Your Past Medical History:(Check any conditions you currently have or have had in the past)

__Aids/HIV	__Emphysema	__Multiple Sclerosis	__Surgery 1/ _____
__Alcoholism	__Epilepsy	__Mumps	2/ _____
__Allergies	__Goiter	__Pacemaker	3/ _____
__Appendicitis	__Gout	__Pneumonia	__Thyroid Disorders
__Arteriosclerosis	__Heart Disease	__Polio	__Trauma (fall, car accident,etc.)
__Asthma	__Hepatitis	__Rheumatic Fever	__Tuberculosis
__Cancer	__Herpes	__Scarlet Fever	__Ulcers
__Chicken Pox	__Hypertension	__Seizures	__Venereal Disease (STD's)
__Diabetes	__Measles	__Stroke	__Other: _____

Your Diet:

Appetite: __Low __High Cravings? _____ How many meals/day? _____
__Coffee __Tea __Soft Drinks __Ice in drinks? __Cups of water/day __Vegan

Your Lifestyle:

__Marijuana __Stress __Alcohol Regular Exercise? Y / N
__Job Hazards __Drugs __Tobacco Type_____Frequency_____

General Symptoms:

__Poor appetite	__Poor sleep	__Heavy arms/legs	__Chills
__Excessive hunger	__Difficult waking up	__Cold hands or feet	__Night sweats
__Strongly like cold drinks	__Excessive dreaming	__Poor circulation	__Sweat easily
__Strongly like hot drinks	__Fatigue	__Shortness of breath	__Muscle cramping
__Recent weight loss/gain	__Bleed/bruise easily	__Fever	__Vertigo/Dizziness

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Head, Eyes, Ears, Nose, Throat:

__Glasses/Contacts
__Eye strain
__Eye pain
__Red eyes
__Itchy eyes
__Spots in eyes
__Poor vision
__Blurred vision

__Night blindness
__Glaucoma
__Cataracts
__Teeth problems
__Grinding teeth
__TMJ
__Facial pain
__Gum problems

__Tongue/Lip sores
__Dry mouth
__Excessive saliva
__Sinus problems
__Excessive mucus
Color of mucus: _____

__Sore throat
__Lump in throat
__Nose bleeds
__Ringing in ears
__Poor hearing
__Earaches
__Headaches
__Migraines

Respiratory:

__Difficulty breathing when lying down
__Shortness of breath

__Tight chest
__Asthma/wheezing
__Coughing blood

__Cough
Wet or Dry?_____
Thick or thin mucus?

Color of mucus: _____

Cardiovascular:

__High blood pressure
__Blood clots

__Low blood pressure
__Fainting

__Chest pain
__Diffucult breathing

__Tachycardia
__Heart Palpitations

Gastrointestinal:

__Nausea
__Vomiting
__Acid reflux
__Gas
__Bloating
__Hiccup
__Bad breath

__Diarrhea
__Constipation
__Laxative use
__Black stools
__Bloody stools
__Mucus in stools
__Undigested food in stools

__Cramping
__Itchy anus
__Burning anus
__Rectal pain
__Hemorrhoid
__Anal fissures

Bowel movements:
Color: _____
Frequency: _____
Texture/Form: _____
Strong odor: Y / N
Do you have a bowel movement immediately upon waking? Y / N

Musculoskeletal:

__Neck/shoulder pain
__Muscle pain

__Upper back pain
__Lower back pain

__Joint pain
__Rib pain

__Muscle cramping
__Limited range of motion

Skin and Hair:

__Rashes __Eczema
__Hives __Itching
__Acne __Fungus

__Psoriasis
__Ulcerations
__Dandruff

__Hair loss
__Dry skin
__Oily skin

Other hair or skin problems:
_____
_____

Neuropsychological:

__Numbness
__Tics

__Poor memory
__Depression

__Stress/Anxiety
__Irritability

__Abuse survivor
__Considered suicide

Genito-Urinary:

__Pain on urination
__Frequent urination
__Urgent urination
__Impotence

__Blood in urine
__Incontinence
__Incomplete urination
__Premature ejaculation

__Bedwetting
__Wake to urinate

__Decreased libido
__Increased libido
__Kidney stone
__Nocturnal emission

Gynecology:

Age menses began: _____
Length of cycle: _____
__Breast lumps
__Irregular periods
__Painful periods

__Vaginal sores
__Vaginal odor
__Vaginal discharge(color) _____

__PMS
__Clots
__Cramping
__Tiredness

__Menopause/Age began:_____
# of pregnancies _____
# of births _____
Date of last PAP: _____
Date last menses: _____

All statements are true and correct to the best of my knowledge. Please sign and date below.

Patient Signature: _____ **Date:** _____