OLD TOWN ACUPUNCTURE
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Licensed Acupuncturist (CO)

Medical History
Confidential

Patient Information
Name: _____Sex: M F
DOB: _____Age:_____
Home Phone: _____Work Phone:_____
_____
Street Address:_____
City: _____State:_____Zip:_____
E-mail:_____
Person to Contact in an emergency:_____
Day Phone: _____
Other Contact Information:_____

Main Complaint:
What you would like help with?
_____
_____
_____
How long have you had this problem?
_____
Did this problem onset suddenly or gradually?
_____
Have you been given a medical diagnosis for this problem? If so, what?
_____

Medical History
Please indicate any of the following significant illnesses and the date of occurrence…
_____ Cancer _____ Diabetes _____ Hepatitis
_____ Thyroid Disease _____ Respiratory Allergies _____ Seizures
_____ Food Allergies _____ Venereal Disease _____ Heart Disease
_____ High Blood Pressure _____ Rheumatic Fever
Other:_____

Musculo-Skeletal
Please describe areas you experience pain:
_____
_____
_____
Please check any sensations of pain that may apply:
___ Sharp ___ Empty ___ Worse when Humid
___ Dull ___ Tight ___ Worse when Dry
___ Throbbing ___ Heavy ___ Worse when Hot
___ Distending ___ Moving ___ Worse when Cold
___ Cramping ___ Stabbing ___ Aggravated by Diet
___ Burning ___ Worse in the Day ___ Worse with Stress
___ Cutting ___ Worse at Night
When did you first experience discomfort or pain?
_____
If the pain is due to an injury, or your know the cause of the pain, please explain.
_____
_____
Is there anything that makes this pain feel better, or worse?
Better:_____Worse:_____

Surgery
Please list your past surgeries, and their dates.
_____
_____
_____

General
Please check if you have experienced any of the following in the last 3 months…
___ Poor Appetite ___ Localized Weakness ___ Sudden Energy Drop
___ Hearing Loss ___ Fevers ___ Sweat Easily
___ Easy to Bleed or Bruise ___ Peculiar Tastes or Smells ___ Fatigue
___ Strong Thirst ___ Poor Sleeping ___ Chills
___ Tremor ___ Poor Balance ___ Weight Loss
___ Night Sweats ___ Cravings ___ Weight Gain
___ Change in Appetite ___ Puffiness or Swelling
Other: _____
Skin and Hair
___ Rashes ___ Itching ___ Dandruff
___ Skins Ulcers ___ Eczema ___ Hair Loss
___ Hives ___ Pimples ___ Recent Moles

Head, Eyes, Nose, and Throat

___ Dizziness ___ Glasses ___ Poor Vision
___ Cataracts ___ Ear Ringing ___ Sinus Problems
___ Teeth Grinding ___ Teeth Problems ___ Gum Problems
___ Headaches ___ Concussions ___ Eye Strain
___ Night Blindness ___ Blurry Vision ___ Poor Hearing
___ Nose Bleeds ___ Facial Pain ___ Jaw Click
___ Migraine ___ Eye Pain ___ Color Blindness
___ Ear Aches ___ Spots in Front of Eyes ___ Recurrent Sore Throat
___ Lip or Tongue Sores

Cardiovascular

___ High Blood Pressure ___ Low Blood Pressure ___ Irregular Heartbeat
___ Cold Hands or Feet ___ Blood Clots ___ Palpitations
___ Swelling of Hands ___ Phlebitis ___ Chest Pain
___ Swelling of Feet ___ Fainting ___ Light Headedness

Respiratory

___ Cough ___ Bronchitis ___ Difficult Breathing
___ Phlegm ___ Coughing up Blood ___ Pneumonia
___ Asthma ___ Painful Breathing ___ Other: _____

Gastro-Intestinal

___ Nausea ___ Constipation ___ Diarrhea
___ Bad Breath ___ Black Stools ___ Abdominal Pain
___ Chronic Laxative Use ___ Vomiting ___ Intestinal Gas
___ Blood in Stools ___ Rectal Pain ___ Belching
___ Indigestion ___ Hemorrhoids ___ Loss of Appetite

Genito-Urinary

___ Painful Urination ___ Urgency to Urinate ___ Unable to Hold Urine
___ Decrease in Urine Flow ___ Frequent Urination ___ Blood in Urine
___ Cloudy Urine ___ Kidney Stones ___ Herpes
___ Genital Sores ___ Frequent Night Urination.

Gynecology - Pregnancy

___ Irregular Periods ___ Clots ___ Premature Births
___ Painful Periods ___ PMS ___ Miscarriages
___ Heavy Flow ___ Vaginal Discharge ___ Abortions
___ Light Flow ___ Yeast Infections ___ Menopausal
___ Spotting ___ Vaginal Sores ___ Postmenopausal

Age of 1 st Menses, _____. Date of last Menses, _____. Duration of Menses, _____

Number of days from 1 st day of menses to 1 st day of next menses, _____ days.

Number of live births, _____, complications?

_____

Neuro – Psychological

___ Seizures ___ Numb Body Areas ___ Concussion
___ Twitches ___ Lack of Coordination ___ Depression
___ Bad Temper ___ Loss of Balance ___ Stress
___ Poor Memory ___ Anxiety ___ Mood Swings
___ Irritability ___ Tremors ___ Other _____

Diet – Personal Habits

Which of the following best describes your diet?

___ Vegan (eats no eggs, dairy, nor any meat of any kind)
___ Lacto-ovo Vegetarian (eats vegetables and fruit plus eggs and dairy products)
___ Semi-Vegetarian (east vegetables and fruits plus eggs, dairy products, fish, and poultry)
___ Omnivore (eats all foods)

Do you have any food allergies? If so, to what?

_____
_____

Please list any medications, vitamins, or supplements that you are taking.

_____
_____
_____

Thank You For Filling Out This Form. All Information Is Strictly Confidential..