Capital Acupuncture Clinic

Patient History & Symptom Review

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name ______________________________ Date ______________

Street ______________________________ Phone ______________

City______________________ St ___ Zip ________ Ok to leave message? (y/n)____

Age ________ Birth Date ______________ E-mail address______________________

Sex: ☐ M ☐ F Height ____________ Weight ____________

Employer ______________________________ Occupation______________________

Name of person we should contact in event of an emergency:

Name ______________________________ Home Phone ______________

Relationship ______________________________ Work Phone ______________

How were you referred to this clinic? ______________________________

MAIN REASON FOR COMING ______________________________

____

When did it begin? (Date) __________ What caused it?______________________

Work-related? Y ☐ N ☐ DK ☐ Accident? Y ☐ N ☐ What kind? ______________

What makes it better? heat ☐ cold ☐ activity ☐ rest ☐ other ______________

What makes it worse? heat ☐ cold ☐ activity ☐ rest ☐ other ______________

Is it getting worse? Y ☐ N ☐ Does it interfere with? work ☐ sleep ☐ daily routine ☐

Have you received treatment for this problem? Y ☐ N ☐ If yes:

Who?	When?	Treatment	Did it help?
__________	__________	__________	Y ☐ N ☐
__________	__________	__________	Y ☐ N ☐

OTHER REASONS FOR COMING

1. ______________________________
2. ______________________________
3. ______________________________

OTHER HEALTH ISSUES/GOALS

Improve energy levels ☐ Gain or lose weight ☐ Improve immunity ☐ Clear skin ☐

Improve diet/nutrition ☐ Reduce reliance on ______________________ (caffiene, tobacco, etc.)

OVERALL HEALTH

Considering your age, how would you describe your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor In general, how satisfied are you with your life? ☐ Very satisfied ☐ Mostly satisfied ☐ Mostly disappointed

PERSONAL HEALTH HISTORY

ILLNESSES/INJURIES

Have you ever had the following? Check all that apply:

☐	Allergies/hay fever	☐	Diabetes	☐	Frequent infections	☐	Polio
☐	Anemia	☐	Diptheria	☐	Influenza	☐	Prostate problems
☐	Arthritis/gout	☐	Dislocations	☐	Kidney/bladder problems	☐	Psoriasis
☐	Asthma	☐	Diverticulitis	☐	Lifting injuries	☐	Rheumatic fever
☐	Auto accident/injury	☐	Eczema/hives	☐	Measles	☐	Scarlet fever
☐	Bleeding/bruising problem	☐	Emphysema/COPD	☐	Migraines	☐	Sprains
☐	Broken bones	☐	Food, chemical, or drug poisoning	☐	Mononucleosis	☐	Ulcers/stomach disease
☐	Bronchitis	☐	Gallstones/gallbladder disease	☐	Mumps	☐	Stroke
☐	Cancer	☐	Heart disease	☐	Neuritis or neuraligia	☐	Thyroid problems
☐	Chicken pox	☐	Hepatitis A B C	☐	Osteoporosis	☐	Tuberculosis
☐	Colitis or bowel disease	☐	Herpes	☐	Paralysis	☐	Venereal disease
☐	Concussion	☐	High blood pressure	☐	Pleurisy	☐	Whooping cough
☐	Convulsions/epilepsy	☐	Hypoglycemia	☐	Pneumonia		

When was your last:

Physical exam	Date ________________	Results ______________________________
Chest X-Ray	Date ________________	Results ______________________________
Skin exam	Date ________________	Results ______________________________
EKG	Date ________________	Results ______________________________
Other	Date ________________	Results ______________________________

ALLERGIES/SENSITIVITIES

Check all that apply:

Dairy	☐	Molds	☐	Smoke	☐	Penicillen	☐
Citrus	☐	Dust	☐	Grass	☐	Aspirin	☐
Wheat	☐	Weeds	☐	Trees	☐	Codeine or morphine	☐
Alcohol	☐	Pollen	☐	Fumes	☐	Other ______________________	

BLOOD TYPE

Do you know your blood type? O ☐ A ☐ B ☐ AB ☐ Don't know ☐

HOSPITALIZATIONS/SURGERIES

Have you been hospitalized for any illness? N ☐ Y ☐

Reason ______________________________ Month/Year__________ Where ___________________________

Reason ______________________________ Month/Year__________ Where ___________________________

Have you ever had surgery? Give year or age:

Tonsils____________________	Appendix______________________	Hysterectomy ______________	Gall Bladder_____________
Kidney____________________	Heart ______________________	Hernia ____________________	Back/spine _____________
Prostate___________________	Cyst _______________________	Cancer ____________________	Breast__________________

Other ____

Have you ever had a blood or plasma transfusion? N ☐ Y ☐

FOREIGN TRAVEL

Travel in the past ten years: Location ____________________ Year ________ Location ________________________ Year ________

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age/Death	Cause
Father	_____	________________	_____	________________
Mother	_____	________________	_____	________________
Sibling	_____	________________	_____	________________
Sibling	_____	________________	_____	________________
Sibling	_____	________________	_____	________________
Sig. Other	_____	________________	_____	________________
Children	_____	________________	_____	________________
Children	_____	________________	_____	________________
Children	_____	________________	_____	________________

Has any blood relative ever had:	Who?
Cancer	______________________
Tuberculosis	______________________
Diabetes	______________________
Heart Trouble	______________________
High Blood Pressure	______________________
Stroke	______________________
Epilepsy	______________________
Suicide	______________________
Other	______________________

EXERCISE

I exercise _________ days/week. Activities ____

Are you satisfied with your level of fitness? Y ☐ N ☐

What physical activities do you enjoy doing or are interested in?______________________________

SLEEP

How many hours of sleep do you usually get a night? _____ Do you sleep well? Describe ______________________

____

Do you wake feeling refreshed? Always ☐ Usually ☐ Rarely ☐ Never ☐

REVIEW OF SYSTEMS

If you have the symptoms below, please check the box that best describes their severity. If you had the symptom in the past, check the box. If you have the symptom currently, circle the box like this: (☐) If you don't have symptoms, leave blank.

1 = mild/sometimes 2 = moderate/often 3 = severe/constant

GENERAL	1	2	3		1	2	3		1	2	3
Unintentional weight loss	☐	☐	☐	Difficulty sleeping	☐	☐	☐	Feel warmer than others	☐	☐	☐
Unexplained fevers	☐	☐	☐	Strong thirst	☐	☐	☐	Feel colder than others	☐	☐	☐
Swollen lymph nodes	☐	☐	☐	Night sweats	☐	☐	☐	Vertigo or dizziness	☐	☐	☐
Unusual or unexplained fatigue	☐	☐	☐	Change in appetite	☐	☐	☐	Accident prone	☐	☐	☐
Unusual or increased bleeding	☐	☐	☐	Unusual skin rashes	☐	☐	☐				

MUSCULOSKELETAL	1	2	3		1	2	3		1	2	3
Aching muscles or joints	☐	☐	☐	Numbness	☐	☐	☐	Neck pain	☐	☐	☐
Joint pain or swelling	☐	☐	☐	Tingling	☐	☐	☐	Low back pain	☐	☐	☐
Bones painful or sore	☐	☐	☐	Problems walking	☐	☐	☐	Tremors	☐	☐	☐
Painful fingers	☐	☐	☐	Unable to sit straight	☐	☐	☐	Muscle jerking	☐	☐	☐
Painful feet	☐	☐	☐	Loss in height	☐	☐	☐	Leg cramps	☐	☐	☐
Weakness in arms or legs	☐	☐	☐	Elbow pain	☐	☐	☐	Wrist pain	☐	☐	☐
Knee pain	☐	☐	☐	Hip pain	☐	☐	☐	Headaches	☐	☐	☐
Shoulder pain	☐	☐	☐								

EYES, EARS, NOSE, THROAT	1	2	3		1	2	3		1	2	3
Eye pain or itching	☐	☐	☐	Ringing in ears	☐	☐	☐	Difficulty swallowing	☐	☐	☐
Blurry vision	☐	☐	☐	Hearing loss	☐	☐	☐	Pain on swallowing	☐	☐	☐
Double vision	☐	☐	☐	Ear pain	☐	☐	☐	Toothache	☐	☐	☐
See halos or lights	☐	☐	☐	Discharge from ear	☐	☐	☐	Chronic sore tongue	☐	☐	☐
Wear glasses or contacts	☐	☐	☐	Repeated nosebleeds	☐	☐	☐	Sore or bleeding gums	☐	☐	☐
Watering eyes	☐	☐	☐	Runny nose	☐	☐	☐	Dry throat	☐	☐	☐
Glaucoma	☐	☐	☐	Chronic nose obstruction	☐	☐	☐	Snoring	☐	☐	☐
Night blindness	☐	☐	☐	Sinus pain	☐	☐	☐	Hoarse voice	☐	☐	☐
Cataracts	☐	☐	☐	Head colds	☐	☐	☐	Swelling in neck	☐	☐	☐
Strange odors or taste	☐	☐	☐	Jaw pain	☐	☐	☐				

HEART, CIRCULATION & LUNGS	1	2	3		1	2	3		1	2	3
Difficult breathing	☐	☐	☐	Sit up to breathe easily	☐	☐	☐	Fainting	☐	☐	☐
Wheezing or gasping	☐	☐	☐	Rapid/skipped beats	☐	☐	☐	Leg cramps	☐	☐	☐
Chronic cough	☐	☐	☐	Swollen feet or ankles	☐	☐	☐	Cramps walking or at night	☐	☐	☐
Cough up blood	☐	☐	☐	Chest pain	☐	☐	☐	Varicose veins	☐	☐	☐
Asthma	☐	☐	☐	Chest pain on effort	☐	☐	☐	Cold hands/feet	☐	☐	☐
Daily sputum production	☐	☐	☐	High blood pressure	☐	☐	☐				
Catch colds easily	☐	☐	☐	Low blood pressure	☐	☐	☐				

THYROID	1	2	3		1	2	3		1	2	3
Swollen or bulging eyes	☐	☐	☐	Gain weight easily	☐	☐	☐	Strong urine	☐	☐	☐
Cold hands/feet	☐	☐	☐	Loss of weight	☐	☐	☐	Slow reflexes	☐	☐	☐
Trouble awakening	☐	☐	☐	Dry skin	☐	☐	☐	Thick skin/fingernails	☐	☐	☐

GASTROINTESTINAL	1	2	3		1	2	3		1	2	3
Nausea	☐	☐	☐	Loss of appetite	☐	☐	☐	Gray/whitish stools	☐	☐	☐
Heartburn	☐	☐	☐	Gas	☐	☐	☐	Mucus in stools	☐	☐	☐
Frequent belching	☐	☐	☐	Bloating	☐	☐	☐	Alt. loose stools/constipation	☐	☐	☐
Vomiting	☐	☐	☐	Constipation	☐	☐	☐	Rectal itch	☐	☐	☐
Stomach pain w/stress	☐	☐	☐	Diarrhea or loose stools	☐	☐	☐	Rectal pain	☐	☐	☐
Fatigue after eating	☐	☐	☐	Blood in stools	☐	☐	☐	Hemorrhoids	☐	☐	☐
Abdominal pain/cramps	☐	☐	☐	Black stools	☐	☐	☐	Change in bowel habits	☐	☐	☐
Food allergies; list foods											

LIVER/GALL BLADDER	1	2	3		1	2	3		1	2	3
Skin turns yellow	☐	☐	☐	Sensitive to medications	☐	☐	☐	Floating stools	☐	☐	☐
Skin itches	☐	☐	☐	Insensitive to medications	☐	☐	☐	Pain under right ribcage	☐	☐	☐
Intolerance of fatty foods	☐	☐	☐	Headaches after eating	☐	☐	☐				

KIDNEYS & BLADDER	1	2	3		1	2	3		1	2	3
Frequent or excess urination	☐	☐	☐	Pain with urination	☐	☐	☐	Scanty urine	☐	☐	☐
Retention of urine	☐	☐	☐	Burning on urination	☐	☐	☐	Constant urge to urinate	☐	☐	☐
Difficulty starting urination	☐	☐	☐	Leakage of urine	☐	☐	☐	Kidney stones	☐	☐	☐
Wake up to urinate	☐	☐	☐	Brown, black or bloody urine	☐	☐	☐				

SKIN

	1 2 3		1 2 3		1 2 3
Rashes	☐ ☐ ☐	Hives	☐ ☐ ☐	Hair loss	☐ ☐ ☐
Acne	☐ ☐ ☐	Ulcerations	☐ ☐ ☐	Purpura	☐ ☐ ☐
Eczema	☐ ☐ ☐	Dandruff	☐ ☐ ☐	Bruise easily	Y ☐ N ☐
Psoriasis	☐ ☐ ☐	Itching	☐ ☐ ☐		

Any recent skin or hair changes?____

Any unusual skin problems or sores?____

Any sores which will not heal or bleed easily? Where?____

EMOTIONS

Anxiety	☐ ☐ ☐	Hopeless outlook	☐ ☐ ☐	Poor memory	☐ ☐ ☐
Depression	☐ ☐ ☐	Lonely	☐ ☐ ☐	Dislike criticism	☐ ☐ ☐
Bad temper	☐ ☐ ☐	Easily stressed	☐ ☐ ☐	Nervousness	☐ ☐ ☐

Have you ever attempted suicide? Y ☐ N ☐ ____

How close are your social ties with family and friends? ☐ Very close ☐ Somewhat close ☐ Somewhat distant ☐ Very distant

Are you involved in an abusive relationship? Y ☐ N ☐ Have you been physically, sexually or emotionally abused in the past? Y ☐ N ☐

Have you ever been treated for mental or emotional problems? Y ☐ N ☐

MEN'S HEALTH

Burning or discharge from penis	☐ ☐ ☐	Premature ejaculation	☐ ☐ ☐	Low sex drive	☐ ☐ ☐
Painful testicles	☐ ☐ ☐	Sores on penis or scrotum	☐ ☐ ☐	Erection problems	☐ ☐ ☐
Lumps or swelling on testicles	☐ ☐ ☐	Varicose veins in scrotum	☐ ☐ ☐	Prostate problems	☐ ☐ ☐
Ejaculation pain	☐ ☐ ☐	Low sperm count	☐ ☐ ☐		

Do you do regular scrotum self exams? Y ☐ N ☐ How often? ______________________

WOMEN'S HEALTH

Menstrual History

Age started menstruation ___________ Date of most recent period _______________ Do you use: tampons ☐ pads ☐

Are your periods regular? Y ☐ N ☐ Days between periods____________________ Period lasts _________________ days

Bleeding is: light ☐ medium ☐ heavy ☐ Do you bleed between periods? Y ☐ N ☐

Do you have painful periods? N ☐ Yes: mild ☐ medium ☐ severe ☐

Do you have pelvic inflammatory disease? Y ☐ N ☐ Do you have unusual vaginal discharge? Y ☐ N ☐ Describe ________________________

Do you have recurrent vaginal/bladder infections? Y ☐ N ☐

When was your last: gynecological exam ___________ Pap smear____________ Mammogram___________ Breast exam__________

Have you ever had an abnormal Pap or mammogram? Describe____

Do you perform regular breast self-exams? Y ☐ N ☐ How often? __________________ Any breast masses? Y ☐ N ☐

Any nipple discharge? Y ☐ N ☐ Have you been told you are going or have you gone through menopause? Y ☐ N ☐

Menstrual Symptoms

Is PMS a health issue for you? Y ☐ N ☐

	1 2 3		1 2 3		1 2 3
Nervous tension	☐ ☐ ☐	Abdominal bloating	☐ ☐ ☐	Depression	☐ ☐ ☐
Mood swings	☐ ☐ ☐	Headache	☐ ☐ ☐	Forgetfulness	☐ ☐ ☐
Irritability	☐ ☐ ☐	Sweet cravings	☐ ☐ ☐	Crying	☐ ☐ ☐
Anxiety	☐ ☐ ☐	Increased appetite	☐ ☐ ☐	Confusion	☐ ☐ ☐
Weight gain	☐ ☐ ☐	Heart pounding	☐ ☐ ☐	Insomnia	☐ ☐ ☐
Swelling of extremities	☐ ☐ ☐	Fatigue	☐ ☐ ☐	Breast tenderness	☐ ☐ ☐
Dizziness or faintness	☐ ☐ ☐	Hot flashes	☐ ☐ ☐		

Birth Control

What methods of birth control are you now using or have used in the past? Check all that apply.

Birth control pills	Now ☐	Past ☐	When taken? ______________________		
IUD	Now ☐	Past ☐	Diaphragm	Now ☐	Past ☐
Condoms	Now ☐	Past ☐	Cervical cap	Now ☐	Past ☐
Foam	Now ☐	Past ☐	Tubal ligation	Now ☐	Past ☐
Rhythm method	Now ☐	Past ☐	Partner is sterile or vasectomy	Now ☐	Past ☐
None	☐		Not applicable	☐	

Birth History

Number of pregnancies ____________________ Number of children __________________

Type of delivery: Vaginal _____________ Caesarean ______________________

Did you breast feed your babies? Y ☐ N ☐