Living Water Acupuncture
& Chinese Herbal Medicine

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Name_____ Phone (H) _____ (W)_____

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Place of Birth _____

Height _____ Weight _____ Marital Status _____ SS # _____

Employer Name & Address_____

Family Physician _____ Referred By _____

Insurance Company _____ Policy # _____

Emergency Contact _____ Phone_____

Email Address _____Today's date _____

Have You Been Treated By Acupuncture or Oriental Medicine Before?: Yes □ No □

Main Problem(s) you would like help with _____

_____

How long ago did this problem begin (be specific)? _____

_____

To what extent does this problem interfere with your daily activities (work, sleep, etc)? _____

_____

Have you been given a diagnosis for this problem: If so, what? _____

_____

What kinds of treatment have you tried? _____

_____

_____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____ High Blood Pressure _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____

Seizures _____ Venereal Disease _____ HIV/AIDS _____ Other _____

Surgeries (type of and date)_____

_____

Significant Trauma (auto accidents, falls, etc) _____

_____

Significant Dental Work (type and date)_____

Birth History (prolonged labor, forceps delivery, etc) _____

Allergies (drugs, chemicals, foods/result) _____

Family Medical History (check): Diabetes □ Cancer □ High Blood Pressure □

Heart Disease □ Stroke □ Seizures □ Asthma □ Allergies □

Other □_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc) _____

_____

_____

Occupational Stress (physical, chemical, psychological, etc) _____

_____

Do you have a **regular exercise program**? Yes □ No □ Please Describe _____

_____

Have you ever been on a **restricted diet**? Yes □ No □ What Kind? _____

_____

Please describe your **average daily diet**:

Morning_____

Afternoon_____

Evening_____

How many **packs of cigarettes** do you smoke per day? _____

How much **coffee, tea or cola** do you drink per day? _____

How much **alcohol** do you drink per week? _____

Please describe any use of recreational drugs _____

Please check any you have had in the last three months:

General

□ Poor appetite
□ Localized weakness
□ Strong thirst (cold or hot) what time of day? _____
□ Tremors□ Poor balance
□ Cravings
□ Weight loss
□ Fevers
□ Bleed or bruise easily
□ Thirst, no desire to drink
□ Poor sleep
□ Fatigue
□ Change in appetite
□ Sweat easily
□ Peculiar tastes or smells
□ Sudden energy drop –
□ Chills
□ Night sweats
□ Weight gain

Skin and Hair

□ Rashes
□ Change in hair or skin
□ Loss of Hair
□ Recent moles
□ Itching
□ Ulcerations
□ Hives
□ Other hair or skin problems
□ Dandruff
□ Eczema
□ Pimples

Head, Eyes, Ears, Nose, and Throat

□ Dizziness
□ Cataracts
□ Grinding teeth
□ Eye strain
□ Poor hearing
□ Jaw clicks
□ Color blindness
□ Recurrent sore throats
□ Glasses
□ Ringing in ears
□ Teeth problems
□ Night blindness
□ Nose bleeds
□ Migraines
□ Earaches
□ Sores on lips or tongue
□ Poor vision
□ Sinus problems
□ Concussions
□ Blurry vision
□ Facial pain
□ Eye pain
□ Spots in front of eyes
□ Headaches - where and when_____

□ Other head or neck problems _____

Cardiovascular

□ High blood pressure
□ Blood clots
□ Swelling of hands
□ Fainting
□ Irregular heartbeat
□ Low blood pressure
□ Phlebitis
□ Swelling of feet
□ Cold hands or feet
□ Dizziness
□ Chest pain
□ Difficulty in breathing

□ Other heart or blood vessel problems _____

Respiratory

□ Cough
□ Difficulty in breathing when lying down
□ Production of phlegm ; if so, what color _____
□ Pneumonia
□ Other lung problems _____
□ Bronchitis
□ Asthma
□ Coughing blood
□ Pain with a deep breath

Gastrointestinal

□ Nausea
□ Bad breath
□ Vomiting
□ Rectal pain
□ Constipation
□ Abdominal pain or cramps
□ Gas
□ Diarrhea
□ Black stools
□ Chronic laxative use
□ Blood in stools
□ Belching

□ Indigestion □ Hemorrhoids
□ Other stomach or intestinal problems_____

Genito-urinary

□ Pain on urination □ Urgency to urinate □ Frequent urination
□ Unable to hold urine □ Impotency □ Blood in urine
□ Kidney stones □ Sores on genitals □ Other genital or urinary system problems _____
□ Do you wake up to urinate? □ Yes □ No. How often? _____
Any particular color to your urine? _____

Pregnancy and Gynecology

Number of pregnancies ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
First day of last menses ____
_____

□ Unusual character (heavy or light) □ Painful periods □ Vaginal discharge
□ Changes in body/psyche prior to menstruation □ Clots
□ Vaginal sores
□ Irregular periods □ Last Pap _____ □ Breast lumps

Do you practice birth control?
□ Yes □ No
What type and for how long? _____

Musculoskeletal

□ Neck pain □ Back pain □ Hand/wrist pain
□ Muscle pain □ Muscle weakness □ Shoulder pain
□ Knee pain □ Foot/ankle pain □ Hip pain

Neuropsychological

□ Seizures □ Areas of numbness □ Concussion
□ Bad temper □ Dizziness □ Lack of coordination
□ Depression □ Easily susceptible to stress □ Loss of balance
□ Poor memory □ Anxiety □ Other neurological or psychological problems_____

Please note the severity of your problem now:

No Problem _____Worst Imaginable

Please note the severity of your problem within the last week:

No Problem _____Worst Imaginable

Comments (please mention any other problems you would like to discuss):

_____
_____
_____
_____
_____

Indicate painful or distressed areas: