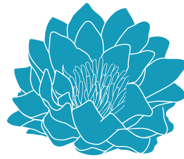
MARIAN SMALL ND MAc LAc RN

Family Practice Oriental Medicine



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) ____

____

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

Skin and Hair

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

Head, Eyes, Ears, Nose, and Throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness

- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches - where and when ________________ ______________________
- ☐ Other head or neck problems ______________ ______________________

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing
- ☐ Other heart or blood vessel problems ______________ ______________________

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm what color _____________
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Other lung problems _____ ______________________

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ 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?

____

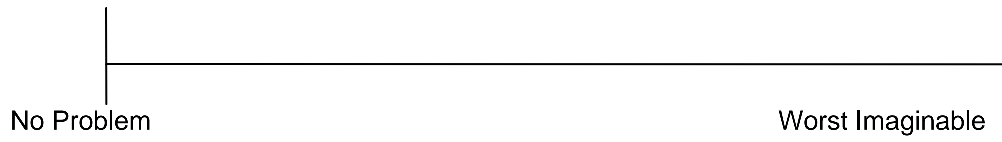
Musculoskeletal

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

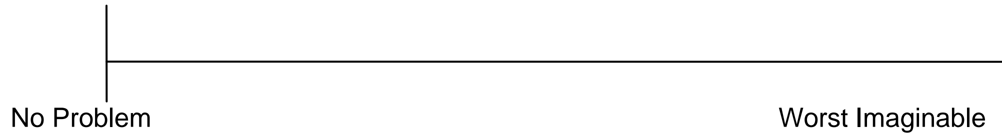
Neuropsychological

- ☐ 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:



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



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

Indicate painful or distressed areas: