



## Carbondale Acupuncture Center, Inc.

54 Weant Blvd., Carbondale, CO 81623 (970) 704-1310

Name: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Main complaint (describe in detail):

Personal Medical History:

Family Medical History (siblings, parents, grandparents):

Diet:      Breakfast      Lunch      Dinner      Snacks

Coffee: \_\_\_\_\_ Sodas: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Cigarettes: \_\_\_\_\_ Drugs: \_\_\_\_\_

Types of exercise:

Please use the following marks to indicate if you have any of the following symptoms:

**C-** currently or recently experienced the symptom

**P-** have experienced the symptom in the past

**Energy:**

\_\_\_ Good energy

\_\_\_ Poor energy

Energy drop at \_\_\_ p.m.

**Digestion:**

\_\_\_ Poor appetite

\_\_\_ Excessive appetite

\_\_\_ Thirst

\_\_\_ Lack of thirst

\_\_\_ Abdominal pain

\_\_\_ Gas, bloating

\_\_\_ Nausea, vomit

\_\_\_ Belching

\_\_\_ Bad breath

\_\_\_ Heartburn

\_\_\_ Indigestion

**Stool:**

How many times/day \_\_\_

\_\_\_ Diarrhea

\_\_\_ Loose stools

\_\_\_ Constipation

\_\_\_ Hemorrhoids

\_\_\_ Painful movements

**Urinary:**

How many times/day \_\_\_

\_\_\_ Wake to urinate

\_\_\_ Painful

\_\_\_ Urgent

\_\_\_ Blood in urine

\_\_\_ Cloudy

\_\_\_ Strong odor

\_\_\_ Incontinent

\_\_\_ Bed wetting

**Temperature:**

\_\_\_ Tend to feel hot

\_\_\_ Tend to feel cold

\_\_\_ Feel feverish

\_\_\_ Flushed face

\_\_\_ Cold hands & feet

**Perspiration:**

\_\_\_ Sweat easily

\_\_\_ Night sweats

\_\_\_ Sweaty palms, soles

\_\_\_ Bad odor

\_\_\_ Normal

**General:**

\_\_\_ Catch cold easily

\_\_\_ Tremors/shakes

\_\_\_ Poor memory

\_\_\_ Numbness/tingling

\_\_\_ Loss of weight

**Sleep:**

\_\_\_ Insomnia

\_\_\_ Trouble falling asleep

\_\_\_ Wake in middle of night

\_\_\_ Dream disturbed sleep

\_\_\_ Restless sleep

\_\_\_ Wake up tired

\_\_\_ Wake up refreshed

\_\_\_ Too much sleep

**Respiratory:**

\_\_\_ Shortness of breath

\_\_\_ Asthma

\_\_\_ Cough

\_\_\_ Wheeze

\_\_\_ Tight chest

\_\_\_ Phlegm production

\_\_\_ Sigh a lot

**Cardiovascular:**

- \_\_\_ High blood pressure
- \_\_\_ Chest pain
- \_\_\_ Palpitations
- \_\_\_ Swollen hands/feet
- \_\_\_ High cholesterol

**Skin:**

- \_\_\_ Dry skin
- \_\_\_ Oily skin
- \_\_\_ Itchy skin
- \_\_\_ Rashes
- \_\_\_ Excema
- \_\_\_ Pimples
- \_\_\_ Bruise easily

**Head:**

- \_\_\_ Headaches
- \_\_\_ Migraines
- \_\_\_ Dizziness
- \_\_\_ Concussions

**Nose:**

- \_\_\_ Runny nose
- \_\_\_ Allergies
- \_\_\_ Sinusitis
- \_\_\_ Nosebleeds

**Ears:**

- \_\_\_ Loss of hearing
- \_\_\_ Ringing in ears
- \_\_\_ Earaches

**Eyes:**

- \_\_\_ Dry eyes
- \_\_\_ Itchy eyes
- \_\_\_ Red eyes
- \_\_\_ Blurred vision
- \_\_\_ Floaters/spots in eyes
- \_\_\_ Eye pain

**Throat:**

- \_\_\_ Sore throat
- \_\_\_ Swollen glands
- \_\_\_ Dry throat
- \_\_\_ Lump in throat

**Mouth:**

- \_\_\_ Dry mouth
- \_\_\_ Weird taste in mouth
- \_\_\_ Gum problems
- \_\_\_ Tooth problems
- \_\_\_ Mouth sores
- \_\_\_ Grind teeth
- \_\_\_ T.M.J.

**Pain:**

- \_\_\_ Neck/shoulder pain
- \_\_\_ Upper back pain
- \_\_\_ Low back pain
- \_\_\_ Spinal problems
- \_\_\_ Sciatica
- \_\_\_ Joint pain
- \_\_\_ Arthritis
- Other: \_\_\_\_\_

**Sexual:**

- \_\_\_ Low sex drive
- \_\_\_ Seminal emmision
- \_\_\_ Impotence
- \_\_\_ Herpes
- Other: \_\_\_\_\_

**Emotional:**

- \_\_\_ Generally happy
- \_\_\_ Tend to be sad
- \_\_\_ Easily angered
- \_\_\_ Easily stressed
- \_\_\_ Fearful
- \_\_\_ Anxious
- \_\_\_ Hold emotions in
- \_\_\_ Depressed

**Gynecology:**

- |  |   |
|--|---|
| Age at first menses _____              | Length, in days, of menstrual cycle _____ |
| Number of times pregnant _____         | Days of flow _____ Amount of flow _____   |
| Type of birth control used _____       | Color of flow _____ Clots _____           |
| Vaginal discharge _____                | Pain _____ P.M.S. _____                   |
| Are you or might you be pregnant _____ |   |

**Thank you!** You have finished a long and somewhat arduous task.