Larisa Rich Acupuncture

General information

Name_____**DOB**_____

Address_____**City**_____**State**_____**Zip**_____

Email_____**Home phone**_____**Cell**_____

Married Single Partner Divorced Widowed Occupation_____

Emergency contact_____Phone_____

Family Physician_____contact_____

Have you had Acupuncture before? Yes No what for?_____

Are you presently under doctor's care Yes No what for?_____

Focus

What is your primary reason for seeking acupuncture?_____

_____When did it begin?_____

Have you been diagnosed? Yes No Diagnosis_____

What makes it worse?_____

What makes it better?_____

How does it affect your daily activities? Work Sleep Walking Sitting Standing Going up

Going down Bending Exercising Emotional Social life Relationships Sexually

Other_____

What have you done about this?_____

What are your health goals?_____

List all surgeries (passed and upcoming), injuries and their date_____

_____

_____

_____

_____

What is your diet like? Omnivore Vegetarian Vegan

other_____

Signs/Symptoms

Abdominal distention __
Abuse survivor__
Acid reflux__
Acne__
Asthma__
Bad breath__
Blood in stool__
Blood in urine__
Blurry vision__
Bruise easily__
Chest pain__
Chills__
Cold hands/feet__
Concussion__
Constipation__
Cough__
Decreased __
Depression__
Dizziness/vertigo__
Dry throat/mouth__
Diarrhea__
Ear aches__
Eye pain/strain/tension__
Excessive phlegm__
Excessive saliva__
Fatigue__
Fever__
Frequent urination__
Gas/belching__
Grinding teeth__
Headache__
Hemorrhoids__
Heart palpitations__
Hiccup__
High blood pressure__
Impotence__
Indigestion__
Irritability__
Itchy skin__
Joint pain__
Kidney stones__
Laxative use__
Loss of hair__
Low back pain__
Migraine__
Mouth sores__
Muscle pain__
Nasal congestion__
Neck/shoulder pain__
Night sweats__
Nose bleeds__
Numbness__
Painful urination__
Poor appetite__
Poor memory__
Poor sleep__
Psoriasis__
Rash__
Red eyes__
Seizures__
Short temper__
Shortness of breath__
Sinus pressure__
Spots in eyes__
Sore throat__
Sudden energy drop__
Urgent urination__
Vomiting__
Wake to urinate__
Weight gain/loss__
Wheezing__
Disturbed sleep__
other_____
_____

Women' Health

Date of last menstruation_____Length of cycle_____Length of flow_____Clots_____

Is your period painful? Yes No if Yes, before flow with flow PMS

Birth control Yes No # of pregnancies_____# of births_____# of miscarriages_____

Nights sweats (how often)_____hot flashes (how often)_____

Pregnancy complications_____

Medical History

List your allergies (medication, foods, animals, seasonal)_____
_____

Current medications_____

_____

Supplements_____

Please indicate if you or any family members have or had any of the following conditions

Conditions	Relationship
Pneumonia____	_____
Tuberculosis___	_____
Hepatitis___	_____
Diabetes___	_____
Epilepsy___	_____
Heart attack___	_____
Blood transfusion___	_____
Anemia___	_____
Arthritis___	_____
Obesity___	_____
Mental Breakdown___	_____
Jaundice___	_____
HIV/Aids___	_____
High/low blood pressure___	_____
Heart disease___	_____
Gout___	_____
Cancer ____type_____	
Mental illness___	_____
Hypo/hyper thyroid___	_____
MS___	_____
Parkinson___	_____
Alzheimer___	_____

History of pain

Location(s) of pain_____

Severity of pain (from no pain to high level) 1 2 3 4 5 6 7 8 9 10

Description of pain dull ache shooting stabbing sharp electric

Time of the day when it is worse_____ better_____

Activities that make it worse_____

Better_____

Does it affect? Sleep Y /N Mood Y / N Activities Y / N Social life Y / N

Is it affected by weather? Y / N Hot Cold Rainy Humid

Is it affected by stress? Y / N

History of sleep

Trouble falling asleep (how long does it take?)_____ racing thoughts Yes / No

Early waking (what time?) _____are you rested in the morning? Yes / No

Interrupted sleep (times per night)_____vivid dreaming___Yes / No

Waking to urinate (times per night)_____

History of mood (passed and present, circle what applies)

Prone to stress (passed/present); worries/over thinking (passed/present); anxiety (passed/present); irritability (passed/present); sadness (passed/present); grief (passed/present); depression (passed/present); panic attacks (passed/present); phobias (passed/present); mental illness (passed/present); suicidal thoughts (passed/present); in therapy (passed/present); PTSD.

How stressful is you life? 1 2 3 4 5 6 7 8 9 10

List significant traumas and their dates (emotional, sexual)_____

_____

Name

Signature_____Date_____