The Acupuncture Clinic

MEDICAL SYMPTOMS HISTORY

Patient's Name: ______________________________ Date: ____________________

Major Complaint (s): ____

Please make a check if you have experienced any on the following symptoms now or in the past. The more thorough you are with the following the better outcome you will have with your acupuncture treatment.

Symptom	**Now**	**Past**	**Symptom**	**Now**	**Past**	**Symptom**	**Now**	**Past**
Skin								
eczema	☐	☐	red face	☐	☐	never sweat	☐	☐
acne	☐	☐	face flushes	☐	☐			
cold hands/feet	☐	☐	unusual sweating	☐	☐			
Heart								
palpitation	☐	☐	short of breath	☐	☐	chest pain	☐	☐
Ear, Nose & Throat								
deafness	☐	☐	frequent ear infections	☐	☐	itchy throat	☐	☐
tinnitis (ear ringing)	☐	☐	sinus headaches	☐	☐	constant sinus	☐	☐
itchy ear	☐	☐	yellow mucus	☐	☐	congestion		
ear pain	☐	☐	post-nasal drip	☐	☐	strep throat	☐	☐
sore throat	☐	☐	dry throat	☐	☐			
Gastrointestinal								
constipation	☐	☐	indigestion	☐	☐	ulcer	☐	☐
diarrhea	☐	☐	heartburn	☐	☐	hemorrhoids	☐	☐
no appetite	☐	☐	intestinal gas	☐	☐	ilecocal valve spasm	☐	☐
stomach pain	☐	☐	belching	☐	☐			
Oral Disease								
gums bleeding	☐	☐	mumps	☐	☐	toothache w/out cavities	☐	☐
peridontitis	☐	☐	inflammation of mouth	☐	☐			
dental abscess	☐	☐	TMJ	☐	☐			
Focal Infections:								
rheumatic fever	☐	☐	connective tissue	☐	☐	scarlet fever	☐	☐
arthritis	☐	☐	knee ligaments	☐	☐			

Symptom	Now	Past	Symptom	Now	Past	Symptom	Now	Past
Vascular								
dizziness	☐	☐	migraine	☐	☐	headache with nausea	☐	☐
General								
insomnia	☐	☐	high blood pressure	☐	☐	menstrual cramps	☐	☐
psychosomatic	☐	☐	diabetes	☐	☐	menstrual clotting	☐	☐
weakness			hypoglycemia	☐	☐	heavy periods	☐	☐
hormone imbalance	☐	☐	rheumatism	☐	☐	light periods	☐	☐
exhaustion	☐	☐	colitis	☐	☐	irregular periods	☐	☐
emotional problems	☐	☐	alopecia (baldness)	☐	☐	PMS	☐	☐
asthma	☐	☐	allergies	☐	☐	menopause symptoms	☐	☐
bronchitis	☐	☐	*male:*			# of pregnancies?	______	
hypothyroid (low)	☐	☐	impotence	☐	☐	# of births?	______	
hyperthyroid (high)	☐	☐	premature ejaculation	☐	☐			
low blood pressure	☐	☐	*Female:*					
Other Symptoms								
anemia	☐	☐	taking a long	☐	☐	no energy before	☐	☐
easily catch cold	☐	☐	shower/bath makes you			noontime		
swollen glands	☐	☐	dizzy/faint			energetic in eve, but	☐	☐
easily get	☐	☐	difficulty concentrating	☐	☐	hate the morning		
carsick/seasick			no appetite for breakfast	☐	☐			
feels “spacey”	☐	☐	moody in morning	☐	☐			
Medications & Drugs								
Cigarettes	☐	☐	Cocaine	☐	☐			
Alcohol	☐	☐	Marijuana	☐	☐			

Prescription Drugs:____

Any other symptoms or disease? ____

Have you ever had any surgeries? If so, when where they? ____________________________________

____

What scars do you have? ____