



Welcome to the Telluride Acupuncture Clinic.  
Please print clearly. This information will be kept totally confidential with us. Thank you very much.

Today's date

Last name	First name	Initial
-----------	------------	---------

Address	City	State	Zip
---------	------	-------	-----

Phone	Date of birth	Age	Sex	E-mail
-------	---------------	-----	-----	--------

Work phone	Employer	Occupation	<input type="checkbox"/> Single	<input type="checkbox"/> Separated
			<input type="checkbox"/> Married	<input type="checkbox"/> Divorced

In case of emergency notify	Their phone	Their relationship to you
-----------------------------	-------------	---------------------------

How were you referred to us?
Please list your major health concerns:
What are the major stressors in your life?

Print Name:



If you have had any of the following symptoms, check the box that tell us if the symptom was in the past or is current. Also, circle one of the numbers that appears to the right of the symptom- Circle 1 for the least severe, and 5 for the most severe.

past/current

- Abdominal/stomach pain.....1 2 3 4 5
- Always hungry.....1 2 3 4 5
- Black stools.....1 2 3 4 5
- Blood in stools.....1 2 3 4 5
- Constipation  
(less than daily bowel movement).....1 2 3 4 5
- Diarrhea.....1 2 3 4 5
- Heartburn.....1 2 3 4 5
- Indigestion.....1 2 3 4 5
- Gas.....1 2 3 4 5
- Lack of Appetite.....1 2 3 4 5
- Nausea.....1 2 3 4 5
- Overweight.....1 2 3 4 5
- Unusually thirsty.....1 2 3 4 5
- Vomiting.....1 2 3 4 5
- Weight Changes.....1 2 3 4 5
  
- Bleeding easily.....1 2 3 4 5
- Bleeding gums.....1 2 3 4 5
- Bruising easily.....1 2 3 4 5
- Chest pain or pressure.....1 2 3 4 5
- Dizzy spells or blackouts.....1 2 3 4 5
- Irregular heart beat.....1 2 3 4 5
- Poor circulation.....1 2 3 4 5
- Pounding heart beat.....1 2 3 4 5
- Racing heart beat.....1 2 3 4 5
  
- Chest colds.....1 2 3 4 5
- Chronic cough.....1 2 3 4 5
- Congested nose.....1 2 3 4 5
- Coughing up blood.....1 2 3 4 5
- Smoking.....1 2 3 4 5
- Sneezing .....1 2 3 4 5
- Wheezing.....1 2 3 4 5

past/current

- Earaches.....1 2 3 4 5
- Frequent or extended hoarseness.....1 2 3 4 5
- Hearing difficulties.....1 2 3 4 5
- Nosebleeds.....1 2 3 4 5
- Sinus problems.....1 2 3 4 5
- Sore throat.....1 2 3 4 5
- Sounds/ringing in ears.....1 2 3 4 5
- Swollen glands.....1 2 3 4 5
- Trouble with your eyes.....1 2 3 4 5
- Unusual taste in mouth.....1 2 3 4 5
  
- Dry skin.....1 2 3 4 5
- Itching or burning skin.....1 2 3 4 5
- Skin rash.....1 2 3 4 5
  
- Bloody urination.....1 2 3 4 5
- Burning urination.....1 2 3 4 5
- Difficult urination.....1 2 3 4 5
- Frequent urination.....1 2 3 4 5
- Loss of bladder control.....1 2 3 4 5
- Painful urination.....1 2 3 4 5
- Urination at night.....1 2 3 4 5
  
- Convulsions.....1 2 3 4 5
- Depression.....1 2 3 4 5
- Fatigue or tiredness.....1 2 3 4 5
- Frequent or severe headaches.....1 2 3 4 5
- Difficulty getting to sleep.....1 2 3 4 5
- Difficulty staying asleep.....1 2 3 4 5
- Leg cramps.....1 2 3 4 5
- Nervousness.....1 2 3 4 5
- Numbness or tingling.....1 2 3 4 5
- Shaking or trembling.....1 2 3 4 5
- Stuttering or stammering.....1 2 3 4 5

 **Print name:**

<p>past/current</p> <p><input type="checkbox"/> <input type="checkbox"/> Chills.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive sweating.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Lack of perspiration.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Night sweats.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Tendency to be too cold.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Tendency to be too hot.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain (list other locations):</p>	<p>past/current</p> <p><input type="checkbox"/> <input type="checkbox"/> Back trouble.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain or swelling-any joint.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful feet.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful muscles.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Stiff or painful neck.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Swelling of feet or legs.....1 2 3 4 5</p> <p><input type="checkbox"/> <input type="checkbox"/> Other symptoms:</p>
---	--

**Please check if you have ever had any of the following:**

<p>past/current</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Positive test for AIDS antibodies</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood transfusions</p> <p><input type="checkbox"/> <input type="checkbox"/> Bone disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer or tumor</p> <p><input type="checkbox"/> <input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> <input type="checkbox"/> Colon/Bowel disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Diphtheria</p>	<p>past/current</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug habit</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug sensitivity or reaction</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/mental problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Gall stones</p> <p><input type="checkbox"/> <input type="checkbox"/> Gall bladder problems</p> <p><input type="checkbox"/> <input type="checkbox"/> German measles</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis/jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Hives</p>	<p>past/current</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney or bladder infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> <input type="checkbox"/> Malaria</p> <p><input type="checkbox"/> <input type="checkbox"/> Measles</p> <p><input type="checkbox"/> <input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> <input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Pleurisy</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> <input type="checkbox"/> Polio</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Scarlet fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Small pox</p>
---	---	--

**Other specific illnesses:**

 **Print name:**

Please list previous surgeries and hospitalizations	Please list your typical daily meals	List all current medicines and supplements

**Check if you have a family history of the following:**

<input type="checkbox"/> AIDS <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure	<input type="checkbox"/> Mental illness <input type="checkbox"/> Problems with alcohol <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Other potentially inheritable disease:
--	--	---

**Women- please check if you have had any of the following:**

<p>past/current</p> <input type="checkbox"/> <input type="checkbox"/> Abdominal pain or cramping with menstruation <input type="checkbox"/> <input type="checkbox"/> Abnormal PAP smear <input type="checkbox"/> <input type="checkbox"/> Abortion <input type="checkbox"/> <input type="checkbox"/> Back pain with menstruation <input type="checkbox"/> <input type="checkbox"/> Birth control pills	<input type="checkbox"/> <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> <input type="checkbox"/> Bleeding during or after intercourse <input type="checkbox"/> <input type="checkbox"/> Bloating before periods <input type="checkbox"/> <input type="checkbox"/> Blood discharge from nipples <input type="checkbox"/> <input type="checkbox"/> Breast lumps	<input type="checkbox"/> <input type="checkbox"/> Heavy bleeding with period <input type="checkbox"/> <input type="checkbox"/> Hot flashes <input type="checkbox"/> <input type="checkbox"/> Irregular periods <input type="checkbox"/> <input type="checkbox"/> I.U.D. <input type="checkbox"/> <input type="checkbox"/> Menopause <input type="checkbox"/> <input type="checkbox"/> Miscarriage <input type="checkbox"/> <input type="checkbox"/> Premenstrual tension/syndrome	<input type="checkbox"/> <input type="checkbox"/> Pregnancy <input type="checkbox"/> <input type="checkbox"/> Scanty bleeding with period <input type="checkbox"/> <input type="checkbox"/> Tubal ligation <input type="checkbox"/> <input type="checkbox"/> Sickness/weakness with period <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> <input type="checkbox"/> Vaginal dryness or itching
--	---	---	--

Duration of menstrual periods:	Number of births you have had:
Interval between periods:	Ages of your children:
Date of last period:	Birth control method: