



# Patient's History

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

Current Symptoms \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had acupuncture before? Yes / No

How long have you had this condition? \_\_\_\_\_ Is it getting worse? Yes / No

What is your nature of pain? burning, aching, etc

How is your level of discomfort at rest? (Circle one) 0-1, 2-4, 5-7, 8-10

How is your level of discomfort at moving? (Circle one) 0-1, 2-4, 5-7, 8-10

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_ What seems to make it worse? \_\_\_\_\_

Does it bother your sleep, work, or other? \_\_\_\_\_

Are you under the care of a physician now? \_\_\_\_\_

Other therapies? \_\_\_\_\_

## Family medical history

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Seizure             |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke              |

## Your medical history

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS/ HIV        | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Major trauma     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Typhoid fever    |
| <input type="checkbox"/> Birth trauma     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Polio              | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken pox      | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet fever      | <input type="checkbox"/> Whooping cough   |
| <input type="checkbox"/> Cholesterol      |  |   |   |

List your surgery \_\_\_\_\_

List your daily menu:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

List your Supplements \_\_\_\_\_

Pharmaceutical drug \_\_\_\_\_

Please describe your current exercise regimen:

Hours per week: \_\_\_\_\_ Activities: \_\_\_\_\_ No Exercise \_\_\_\_\_

## Your habit

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> Coffee/tea        | <input type="checkbox"/> Salty food | <input type="checkbox"/> Drugs                |
| <input type="checkbox"/> Soft drink/ juice | <input type="checkbox"/> Alcohol    | <input type="checkbox"/> Stress               |
| <input type="checkbox"/> Sugar Craving     | <input type="checkbox"/> Tobacco    | <input type="checkbox"/> Occupational hazards |

## Check all that apply (past and current)

### General symptoms

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Poor/ Heavy appetite   | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps          |
| <input type="checkbox"/> Strongly like cold/hot | <input type="checkbox"/> Lack of strength   | <input type="checkbox"/> Fever               | <input type="checkbox"/> Vertigo or dizziness   |
| <input type="checkbox"/> Recent wt loss/ gain   | <input type="checkbox"/> Bodily heaviness   | <input type="checkbox"/> Chills              | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Poor/ heavy sleep      | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Night sweats        | <input type="checkbox"/> Taste in mouth         |
| <input type="checkbox"/> Dream-disturb sleep    | <input type="checkbox"/> Poor circulation   | <input type="checkbox"/> Sweat easily        |   |

### Head, eyes, ears, nose, throat

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Myopia or presbyopia   | <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Eye strain      | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Excessive saliva      | <input type="checkbox"/> Poor hearing    |
| <input type="checkbox"/> Eye pain        | <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Red eyes        | <input type="checkbox"/> Teeth problems         | <input type="checkbox"/> Excessive phlegm      | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Itchy eyes      | <input type="checkbox"/> Grinding teeth         | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Spots in eyes   | <input type="checkbox"/> TMJ                    | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Concussions     |
| <input type="checkbox"/> Poor vision     | <input type="checkbox"/> Facial pain            | <input type="checkbox"/> Lumps in throat       | <input type="checkbox"/> Other problems  |
| <input type="checkbox"/> Blurred vision  | <input type="checkbox"/> Gum problems           | <input type="checkbox"/> Enlarged thyroid      |  |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips / tongue | <input type="checkbox"/> Nosebleed             |  |

### Respiratory

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Tight chest      | <input type="checkbox"/> Difficult inhalation? | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> when lying down.     | <input type="checkbox"/> Asthma /wheezing | <input type="checkbox"/> Exhalation            | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Shortness of breath  |   | <input type="checkbox"/> Cough (wet/ dry)      |  |

### Cardiovascular

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Tachy cardia       | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Blood clot          | <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Heart palpitations |   |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Phlebitis          |   |

### Gastrointestinal

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Bloating     | <input type="checkbox"/> Bloody stools         | <input type="checkbox"/> Burning anus    |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Bad breath   | <input type="checkbox"/> Mucous in stools      | <input type="checkbox"/> Rectal pain     |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Hemorrhoid            | <input type="checkbox"/> Laxative use    |
| <input type="checkbox"/> Gas                | <input type="checkbox"/> Constipation | <input type="checkbox"/> Itchy anus            | <input type="checkbox"/> Bowel frequency |
| <input type="checkbox"/> Hiccup             | <input type="checkbox"/> Black stools | <input type="checkbox"/> Intestine pain/ cramp | <input type="checkbox"/> Bowel quality   |

### Musculoskeletal

- |  |  |                                     |                                      |
|--|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Neck/ Shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited ROM |
| <input type="checkbox"/> Muscle pain         | <input type="checkbox"/> Low back pain   | <input type="checkbox"/> Rib pain   |                                      |

### Skin and hair

- |                                    |                                   |  |  |
|------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Rashes    | <input type="checkbox"/> Acne     | <input type="checkbox"/> Hair loss         |  |
| <input type="checkbox"/> Eczema    | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal infections |  |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching  | <input type="checkbox"/> Other             |  |

### Neuropsychological

- |                                   |                                      |  |   |
|-----------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Seizure  | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Considered suicide |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression  | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist |
| <input type="checkbox"/> Tics     | <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Abuse survivor  |   |

### Genitourinary

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Wake to urinate  | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination   | <input type="checkbox"/> Venereal disease     | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Nocturnal emission    |
| <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Bedwetting           | <input type="checkbox"/> Kidney stone     |  |

### Gynecology

- |  |  |                                       |
|--|--|---------------------------------------|
| Age menses began _____                       | Length of cycle _____                      | Duration of flow _____                |
| Date of last PAP _____                       | Date last period began _____               | Age at menopause _____                |
| <input type="checkbox"/> Irregular periods   | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> PMS                 | <input type="checkbox"/> Clots             | <input type="checkbox"/> Pregnancy    |
| <input type="checkbox"/> Menopausal syndrome |  |                                       |



# Your First Visit

## **Acupuncture and your health**

Acupuncture and Oriental medicine take a holistic or whole-body approach to health. This means Dr. Park will take into account your whole self, not just your symptoms, in order to get to the root of your health concerns. You will work together to find out how factors like your lifestyle and emotional and mental well-being may be affecting your health.

## **Your First visit**

Initial visits generally last from 30 to 90 minutes. Dr. Park will take a detailed health history and physical exam, and will provide you with your unique treatment plan.

During your first exam, Dr. Park will spend time getting to know you and your health concerns. You may be asked a wide range of questions about your symptoms, eating exercise, sleep habits, and emotional states-anything that may offer insight into your health.

Your practitioner will also employ diagnostic tools that are unique to acupuncture and oriental medicine such as tongue and pulse diagnosis.

## **Your treatment plan**

Once Dr. Park has gathered enough information, you'll receive a comprehensive diagnosis and a treatment plan that will explain:

- \*Your underlying imbalances
- \*Your time-line of care
- \*What types of treatment you will receive

## **Getting the most out of treatment**

For the best treatment results, keep a few things in mind:

- \*Please show up on time
- \*Avoid large meal and caffeine before your visit
- \*Wear loose, comfortable clothes that can be rolled up to your knees and elbows.
- \*Remove all jewelry, watches before getting acupuncture.
- \*Refrain from overexertion, working out, alcohol for up to 6 hours after the visit
- \*Avoid stressful situations. Make time to relax, and be sure to get plenty of rest
- \*Between visits, take notes of any changes that may have occurred, such as alleviation of pain, pain moving to other areas, changes in the frequency and type of problems.

## **How treatment works**

To treat any Qi imbalances, fine, sterile needles will be inserted at specific points along the meridian pathways. Your acupuncturist may include other related therapies in your treatment plan, such as cupping and Tuina. Herbal remedies are another important aspect of acupuncture and oriental medicine, and it is important to understand and follow Dr. Park's directions in order to get the most benefit from these treatments.

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Between Joselito's and The Time Machine, above Merle Norman  
Enter from the alley ONLY

