CAMDEN ACUPUNCTURE

Amy Jenner — *M.Ac., Dipl.OM., L.Ac.*

Last Name_____ First Name_____ Date_____

Street Address_____ City/Town_____State____Zip_____

Best phone_____ Email_____

Birth Date_____ Age_____ Marital status_____

Occupation_____ Referred by_____

Physcian:_____ Phone:_____

Emergency contact_____Phone_____

Have you received acupuncture in the past 12 months_____

Main Reason for seeking Treatment (symptoms, diagnosis, duration etc.):

_____

_____

_____

_____

Please provide a list of current medications/supplements and the dosage:

_____

_____

_____

_____

_____

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Surgeries (please in include the date of the procedure)_____

_____

Allergies (Chemical, environmental, food, drugs etc.)

_____

Alcohol/recreational drug use (how much, how often) _____

How do you sleep?_____

Exercise (days per week, length of work out, type of activity)

_____

Diet (meals per day, snacks, caffeinated drinks)

Typical Breakfast_____

Typical Lunch_____

Typical Dinner_____

Typical Snacks_____

What makes your condition better? (rest, movement, heat, cold, fresh air, eating, crying, etc.)

_____

_____

What makes your condition worse? (stress, fatigue, certain foods, weather etc.)

_____

_____

Significant trauma (physical or emotional)

_____

_____

_____

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Patient Name:_____Date:_____

Please check any that currently apply to you:

Personal History			
Arthritis	Liver/gallbladder disease	High/low blood pressure	Food allergy/intolerance
Kidney disease	Hypo/hyperglycemia	Stroke	Elevated cholesterol
Cancer	Diabetes	Diverticulitis/IBS	Heart disease
Ulcer	Seizures	Hepatitis	Raynaud's disease
Chronic fatigue	Anemia	Thyroid imbalance	Respiratory allergies
Alcoholism	Lyme disease	Chronic pain	Impotence
Gastritis/pancreatitis	Asthma	Infertility	emphysema
Other:			
Family History ***Please check any condition that applies to your immediate family.*** ***Put an F (father), M (mother), S (sister), B (brother) GM/GF (grandmother/father)***			
Diabetes	Seizures	Heart disease	Stroke
High blood pressure	Allergies	Cancer	Asthma
Other:			
Please check any of the following that you have had in the past year. ***Put a star next to those you have had in the past and don't any longer.***			
General			
Poor appetite	Poor sleeping	Fatigue	Fevers
Chills	Night sweats	Sweat easily	Tremors
Cravings	Localized weakness	Poor balance	Change in appetite
Bleed/bruise easily	Weight loss/gain	Peculiar tastes/smells	Dental/gum problems
Muscle weakness/fatigue	Sudden energy drop	Strong thirst for hot or cold drinks	Running too warm/cold
Other:			
Skin and Hair			
Rashes	Change in skin/hair texture	Hives/allergic dermatitis	Itching
Eczema/psoriasis	Dandruff	Loss of hair	Recent moles
lSkin discoloration	Acne	Face flushing	Ulcerations
Dermatitis	Warts	Fungal infection	Weak or ridged nails
Other:			

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Head, Eyes, Ears, Nose and Throat			
Dizziness	Difficulty swallowing	Migraines	Glasses
Eye strain	Eye pain	Poor vision	Night blindness
Color blindness	Cataracts	Blurred vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes	Sinus problems
Nose bleeds	Recurrent sore throat/colds	Grinding teeth	Facial pain
Sores on lips/tongue	Dental problems	Jaw clicks/locks	Headaches
Other:			
Cardiovascular			
Chest pain or pressure	Irregular heart beat	Palpitations at rest	Fainting
Cold hand/feet	Swelling of hands/feet	Blood clots	Phlebitis
Shortness of breath	Varicose/spider veins	Pressure in chest	High blood pressure
Low blood pressure	Spontaneous sweating	Dizziness	Do you give blood?
Other:			
Respiratory			
Cough/wheeze	Coughing blood	Asthma	Bronchitis
Pneumonia	Difficulty breathing while lying down	Tight sensation in chest	Difficulty inhaling or exhaling
Pain with deep inhale	Production of phlegm	What color?	
Other:			
Gastrointestinal			
Nausea	Vomiting	Diarrhea	Constipation
Gas	Belching	Black stools	Blood in stool
Indigestion	Bad breath	Rectal pain	Hemorrhoids
Bloating/edema	Chronic laxative use	Loose stool (>2/day)	Abdominal pain/cramps
Changes in appetite	Significant thirst	IBS/Crohn's disease	
Other:			
Genito-Urinary			
Pain on urination	Frequent urination	Blood in urine	Urgent urination
Unable to hold urine	Kidney stones	Scanty flow	Copious flow
Impotence	Sores on genitals	Urinary tract infection	Burning urination
Premature ejaculation	Decreased libido	Prostatitis	Dribbling after urine
Nocturnal emission	Pain in testicles	Herpes	Infections
Night urination	What time	How often	
Other:			
Gynecological/Reproductive			
Difficult or painful intercourse	Poly cystic ovarian disease	Age of first menses?	
Vaginal dryness	Endometriosis	Date of last menses?	
Vaginal sores	Uterine fibroids	Date of last PAP/pelvic?	
Vaginal discharge	Fibrocystic breasts	Number of pregnancies?	

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Infertility	Ovarian cysts	Number of ectopic pregnancies?	
Irregular menstruation	PMS	Number of live births?	
Painful Menstruation		Number miscarriages?	
		Number of abortions?	
Do you practice birth control?			
What type?		How long?	

Musculoskeletal

Neck pain	Shoulder pain	Hand/wrist pain	Carpal tunnel
Knee pain	Sprains/strains	Sciatica	Foot/ankle pain
Hip pain	Muscle pain	Muscle weakness	Tendonitis
Back pain Location?			
Soreness/weakness in lower body (back, knee, hip, ankle, foot)			

Neuropsychological

Seizures	Loss of balance	Vertigo/dizziness	Areas of numbness
Lack of coordination	Poor memory	Concussion	Depression
Anxiety/panic attacks	Bad temper/irritable	Easily susceptible to stress	Seasonal affective disorder
Nervousness	ADD/ADHD	Manic depression	
Other:			

Have you been treated for emotional problems?

Have you ever considered or attempted suicide?

Have you ever been treated for substance abuse?

Anything else you'd like to discuss:

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