Patient Name_____

FEEL GOOD acupuncture

PO Box 513
344 East 2nd Street
Bloomsburg PA 17815
http://www.FeelGoodAcupunctureHome.com
tel (570) 854-9498

Date of Office Visit:_____

Patient Contact Information

Patient Name: _____ Phone: _____

Address:

If under 18, Name of Parent or Guardian: _____

Emergency Contact Information

Contact Name: _____ Phone: _____

Relation to Patient: _____

Primary Physician:_____ Phone: _____

General Patient Health Information

Date of Birth: _____ Age: _____ Gender: _____

Weight: _____ Height: _____

Occupation: _____

Have you ever received acupuncture before? Yes No

Have you ever received acupuncture at this office before, if yes, when? Yes No _____

Patient Name_____

Main Complaint

What are you here to have treated today (Main Compliant)?

When did this complaint begin?

Under what circumstances did this complaint begin?

To what extent does this complaint interfere with your daily activities, such as sleep, work, mood or physical activity?

Where you given a medical diagnosis for this complaint? If yes, what?

What other treatments have you tried for this complaint?

Please list any other information that you feel is relevant to this complaint.

Medications

Please list all medications that you are taking and for what purpose.

Herbs and Supplements

Please list all herbs and dietary supplement that you are taking and for what purpose. Please also indicated if they are self-administered or prescribed by your physician or other health professional. If prescribed, please indicate by whom.

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Diet

How many meals a day do you eat?

Do you consistently eat meals at regular times of the day, or does it vary?

Please describe a typical day's meals:

Do you drink caffeinated beverages, if so what kinds and how frequently?

Do you drink alcohol, if so, in what quantities and how frequently?

Describe your daily fluid intake. Please list if this is in the form of water, sodas, fruit juices or other beverages.

Do you have any dietary restrictions? (low-carb, vegetarian, vegan, diabetic, religious)

Have you ever been diagnosed with an eating disorder? If yes, please list.

Exercise

Are you on a regular exercise program? If so please describe.

Family History

Please provide notes on any family health history that you think may be relevant to your health.

Energy Levels and Sleep

___Energy Drop during day (what time_____) ___General Fatigue ___Difficulty falling asleep

___Difficulty Staying Asleep ___Disturbing dreams ___morning grogginess

___Night sweats ___Sweats easily ___Fevers ___Chills

___"runs hot" ___"always cold"

Patient Name_____

Pain

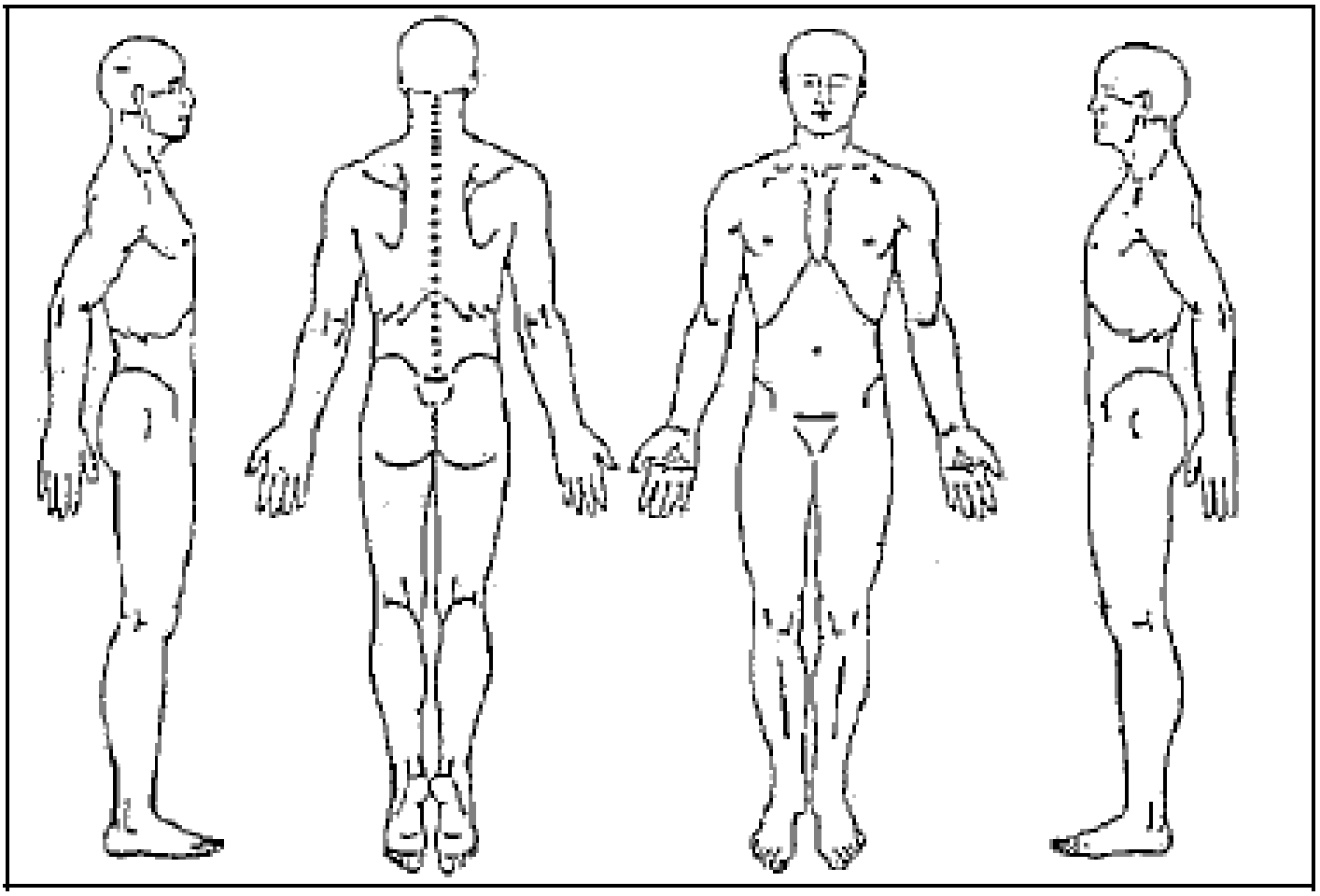
Please describe any pain or discomfort you experience and where. (Please also use the map below).

What is the quality of the sensation? (tingling, numbness, stabbing pain, aching pain, distending pain, alternating sharp and dull pain, pins and needles)

What makes it worse/better? (heat packs, ice, cold weather, damp weather, hot weather, exercise, rest)

Is it worse/better at any time of the day? (worse at night, in the morning, at the end of a work day)

Mark any areas of pain:



Patient Name_____

Head, Ears, Eyes, Nose, Throat & Respiratory

Please check any of the following conditions that apply to you.

___tension headaches (__forehead, __temples, __back of head, __top of head, __behind eyes)

___sinus headaches (__forehead, __cheeks, __behind eyes)

___migraine headaches (__forehead, __temples(L/R/either), __back of head, __top of head, __behind eyes)

___cluster headaches (list where: _____)

___history of head trauma, neck trauma or brain injury (please describe)

___facial pain (list where)

___bell's palsy __trigeminal neuralgia __stroke related facial dysymetry __facial twitching

___Glasses ___Contact Lenses ___Blindness ___Visual Field Cut ___Eye Pain

___Cataracts ___Macular Degeneration (Dry/Wet) ___Blurred Vision

___Itchy eyes ___Dry eyes ___Watery Eyes

___Pressure Behind the Eyes ___Floaters ___Night Blindness

___Post Nasal Drip ___Allergic Rhinitis ___Chronic Sinusitis ___Frequent Sinus infections

___Frequent Nose bleeds ___Frequent Sneezing

__Snoring ___Deviated Septum ___Sleep Apnea

___Earaches ___Frequent Ear Infections ___Ear Discharge __Dizzyness

___Itchy Ears ___Ringing in Ears ___Deaf ___Hearing Loss ___Hearing Aid

___TMJ ___Jaw Clicks ___Teeth Clenching ___Teeth Grinding

___Frequent Cavities ___Bleeding Gums ___Bad Breath ___Mouth Ulcers ___Tongue Ulcers

___Sore Throats ___Hoarseness ___Dry Throat ___Dry Cough

___Productive Cough or ___Frequently Clearing Throat
Amount of Phlegm: __abundant phlegm __little phlegm
Color of Phlegm: __clear __white __yellow __green __grey/black
Presence of blood: __yes __no

__ Asthma (Please indicate type of cough or wheezing if applicable)

___Wheezing ___Chest tightness __Difficulty on exhalation __Difficulty on inhalation

___Frequent Chest Colds ___Frequent Bronchitis __Chronic Bronchitis

___Current Smoker ___Former Smoker ___Emphysema ___Pain with breathing

___Difficulty breathing while lying down

Use this space to provide any additional information regarding the above checked conditions:

Digestive

Please check any of the following conditions that apply to you.

___Poor Appetite ___Gnawing Hunger ___Excessive appetite __Chronic overeater

___weight gain ___weight loss ___Food Cravings (sweet, sour, salt, bitter, spicy, other_____)

___Prefer hot drinks ___Prefer cold drinks

___# Bowel Movements per day OR ___# Bowel Movements per week

___Diarrhea(urgent, with cramping) ___Diarrhea(chronic) ___loose stools

___Sluggish bowel movements (frequently feeling “incomplete”) ___Constipation

___Dry stools ___Sticky Stools ___Hard Stools ___Difficult to pass stools

___Color of stools if not brown (black, grey, green, orange, clay-colored, other: _____)

___Mucous in stools ___Blood in stools ___Hemorrhoids ___Chronic laxative use

___Stomach Ulcers ___Duodenal Ulcers ___Ulcerative Colitis ___Irritable Bowel Syndrome

___Chron’s Disease ___Diverticulitis ___Fistulas ___Fissures

___Colorectal surgery: _____

___Acid reflux ___Burping ___Indigestion ___Bloating

___Vomiting ___Nausea

___Food Allergies (list, specify reaction and specify if anaphylaxis is an exposure risk)

Use this space to provide any additional information regarding the above checked conditions:

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Cardiovascular

Please check any of the following conditions that apply to you.

___High blood pressure (List typical reading_____) ___Low blood pressure (List typical reading_____)

___Heart Attack ___Stroke ___Irregular Heart Rhythm (provide diagnosis_____)

___Cold Hands/Feet ___Swelling Hands/Feet ___Blood clots ___Bruises easily

___Bleeding or Clotting disorder (list_____)

___Angina ___Shortness of breath ___Anemic ___Stroke

Please use this space to explain any of the above conditions:

Endocrine

Please check any of the following conditions that apply to you.

___Hypothyroid ___Hyperthyroid ___Goiter ___Thyroid/Parathyroid Surgery

___Thyroid Replacment Hormone ___Hyperparathyroidism ___Hypoparathyroidism

___Adrenal disorders/diseases/surgeries (please list):

___Insulin Dependent Diabetes ___Adult Onset Diabetes ___Childhood Diabetes

___Diabetic complications (please list)

Neuro-psychological

Please check any of the following conditions that apply to you

___Depression ___Anxiety ___Frustration ___Bad Temper

___Panic Disorder ___Easily Stressed ___Receiving Psych. Treatment

___Considered Suicide ___Attempted Suicide ___Post Traumatic Stress Disorder

___Poor Memory ___Memory Loss ___Concussion ___Lack of Coordination

___Paralysis ___Numbness ___Nerve-related pain

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Skin & Hair

Please check any of the following conditions that apply to you. For skin disorders, specify where.

___Hair Loss __prematurely gray ___dry hair ___dandruff

___moles ___skin cancer ___ulcerations ___lesions

___eczema ___psoriasis ___rashes ___itching

___flaking ___acne ___Changes in skin/hair texture

Urinary

Please check any of the following conditions that apply to you and answer any questions

___Urination Pain ___Blood in Urine ___Cloudy Urine ___Frequent Urinary Tract Infections

___Kidney Stones ___Frequent Urination ___Waking up to urinate more than 1 time/night

___Urinary Urgency with normal urine flow ___Urinary urgency with little urine flow
___Decreased urinary flow or stream ___Color of urine (__clear, ___yellow, __dark yellow/brown)

___Do you take vitamins that may affect the color of your urine?_____ ___Urinary incontinence

___Enlarged Prostate ___Prostate cancer ___Prostate surgery

Reproductive (Male)

Please check any of the following conditions that apply to you

___Impotency due to medication ___Impotency due to other causes(list, if known)_____

___Infertility
___sperm morphology ___sperm motility ___sperm production

___unknown/other please describe

Reproductive (Female)

Please check any of the following conditions that apply to you and answer any questions

_____Age of menarche (first menstruation) (write NA if patient has not had first period)

_____Age of menopause (write NA if patient has not reached menopause)

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Please describe **your average menstrual cycle**:
(When asked “which days”, “day 1” of your cycle is the first day of bleeding)

_____Number of days of complete cycle _____Number of days bleeding

___spotting before period ___spotting at ovulation ___ovulation pain

___period stops and starts ___cramping prior to period (when)_____

___cramping on first couple of days of period (__mild, __moderate, __severe)

___cramping after period (__mild, ___moderate, ___severe)

___Heavy flow (unusually frequent protection change to avoid risk of leaking, or possibly using more than one form of protection, i.e. – super tampon + super pad worn together). (which days?_____)

___Fibroids ___endometriosis

___Regular flow (little risk of leakage during the daytime if changing protection every 3-4 hours, normal protection – regular pads or tampons) (which days?_____)

___Light flow (little or no protection needed) (which days?_____)

___brown menstrual blood (which days?_____)

___purplish menstrual blood (which days?_____)

___fresh red menstrual blood (which days?_____)

___bright or orange menstrual blood (which days?_____)

___pink or pale menstrual blood (which days?_____)

___pea-sized or smaller clots (which days?_____)

___larger than pea-size clots (which days, what color, what size, with cramping?

_____)

The above was a description of your average menstrual cycle. Have you been experiencing irregularities in your cycle?_____

If yes, using the above categorizations, please list how your cycles have been deviating. (Example, changes in color, number of days between bleeding, number of days bleeding, etc.)

Are you taking any medications that regulate your menstrual cycle? If yes, please list:

Have you ever been pregnant?_____ # of live births?_____

# of miscarriages_____ Are you trying to get pregnant now?_____

Is there any chance you could be pregnant now?_____

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If you have children now, how many and what ages?_____

Premature deliveries (#, how early)?_____

Cesarian delieveries (#, why?)_____

Late deliveries or induced labor? (#, how late)_____

___Pregnancy complications
___ Preclampsia ___Gestational diabetes ___threatened miscarriage

___hyperemesis ___other ___hemorrhaging (during or after pregnancy)

___ectopic pregnancies

___Post pregnancy complications
___Uterine prolapse ___changes in menstrual cycle (see above)

___bladder prolapse ___stress incontinence ___post-partum depression

___secondary infertility (see below)

___Tubal Ligation _____Hysterectomy (complete) _____Hysterectomy (ovaries left)

_____Female infertility:

___blocked fallopian tubes ___Polycystic ovary syndrome ___age related hormonal decline

___amenorrhea ___irregular cycle, irregular ovulation

_____other/more specific diagnosis (please provide)

___if unknown, how long have you been trying_____

___Vaginal discharge
(___white, ___yellow, ___green: how long_____, cycle related? Which days?____)

___cervical dysplasia ___frequent yeast infections

___Herpes ___HIV/AIDS ___other STDs_____

___Menopausal complaints (symptoms started with menopause)
___irritability ___frustration ___fatigue ___hot flashes ___night sweats ___other(list)