PATIENT HISTORY FORM
Acupuncture & Oriental Medicine
Donna Kini-Bowen, AP

Name: Phone: Date:

Address: City: State: ZIP:

Ht: WT: Age: Date of Birth: Marital Status:

Home phone: Work/Cell phone:

Email address (optional):

Occupation: Employer: Phone:

Emergency contact's name and phone:

Family Physician's name and phone:

How did you find us (circle): Webpage Physician Referral Friend __ Other:

TREATMENT GOALS:

What is the main condition you would like to address?

Does this affect sleep, work. other?

How long have you had this condition?

What diagnosis, if any, have you been given?

What treatments have you tried (list physician, date, results)?

HEALTH HISTORY:

Current medications (list):

Are you taking blood thinners?

Are you/might you be currently pregnant?

Do you have any implants/pacemaker?

PAST MEDICAL HISTORY:(check all that apply)

_____Allergies	_____Hepatitis	_____Seizures	_____Cancer
_____Diabetes	_____Heart Disease	_____Surgery	_____HIV

_____Stroke _____High Blood Pressure _____Epilepsy
_____Thyroid Disease Other: _____
Surgery History: _____
List previous accidents/injuries/major illnesses _____

LIFESTYLE: (circle yes or no)
Do you exercise regularly? Y / N

Do you smoke? Y / N If yes, how much?

Do you drink alcohol? Y / N If yes, how much?

How much coffee/tea/soda do you drink per day?

How much water do you drink per day?

How often do you eat the following:
Vegetables_____ Candy_____ Dairy_____ Red meat_____ Chips_____
Fruit_____ Fast food_____ Refined carbs (bread, pastries..)_____
Supplements:_____

(Check all that apply):
Energy level:
_____low energy _____low energy after exercise _____lethargic
_____shortness of breath _____sleepy during the day _____fatigue
_____reluctant to talk _____catch cold easily

Circulation/blood:
_____dizziness _____bleeding_____nose bleeds _____floater/spots
_____numbness/tingling in extremities

Lung & Associated TCM functions
_____cough _____dry _____sputum
_____nose bleeds _____dry mouth _____dry skin _____dry throat
_____fever & chills _____Sinus congestion _____dry nose _____sneezing
_____overall achy body
_____sore throat _____difficulty breathing _____feeling sad
_____allergies _____smoke cigarettes _____melancholy
_____headaches: How often?_____

Spleen & Associated TCM functions
_____low appetite _____abdominal gas _____hemmorhoids _____crave sweets
_____gurgling stomach _____bruise easily _____abdominal bloating
_____feel tired after eating _____nose bleed _____nose bleeds
_____worry _____over thinking _____pensive _____loose stools
_____urgent BMs _____diarrhea _____discomfort after BM
_____undigested food in stool _____weight gain
_____blood in stool _____mucus in stool _____constipated

Number of bowel movements per day_____
_____Prolapsed organ. If so, which organ and when_____

Dampness:
_____general feeling of heaviness in body _____mental fogginess_____mental sluggishness
_____nausea _____chest congestion _____vaginal discharge _____overweight
_____swelling. If so, where:

Stomach & Associated TCM Functions:
_____heart burn _____mouth sores _____pain after eating _____large appetite
_____bleeding, painful or swollen gums _____facial swelling/pain _____vomiting
_____bad breath _____acne _____acid regurgitation _____belching
_____hiccups _____stomach pain

Liver/Gallbladder & Associated TCM Functions:
_____Alternating diarrhea and constipation _____High stress level
_____Bitter taste in mouth _____bad temper _____headaches
_____Anger easily _____Irritable _____heat in head/face _____muscle tension
_____Frustration _____Lump in Throat _____muscle twitches
_____Depression _____Feel tense _____gall stones
_____itchy skin/rashes
_____high pitch ringing in ears _____Itch/pain in genitals_____seizure/convulsions
_____discomfort/tightness/tension around ribcage
_____sexually transmitted disease_____

Eyes:
_____itchy _____blood shot _____dry
_____watery _____blurred vision _____poor vision
_____poor vision at night _____eyes feel hot

Heart and Associated TCM Functions:
_____palpitations _____irregular heart beat ____pacemaker _____insomnia
_____poor sleep _____chest pain ____mental confusion_____sore on tip on tongue
_____anxiety _____chest pain arm to shoulder _____restlessness

Kidney and Associated TCM Functions:
_____low back pain/weakness _____weak/sore knees _____cold sensation in low back
_____cold sensation in knees _____wake at night to urinate_____kidney stones
_____bladder/kidney/urinary infection _____memory problems
_____lack of bladder control _____feel fearful _____excessive hair loss/balding
_____easily startled _____frequent broken bones _____frequent cavities
_____libido_____normal_____high_____low

Urination:

_____normal color	_____reddish	_____with blood	_____dark yellow
_____clear	_____cloudy	_____scanty	_____scanty
_____profuse	_____painful	_____dribbling	_____urgent
_____difficult			

_____other:_____

For Women ONLY:

Are you pregnant: Age of first period:

Number of pregnancies: Number of live births:

Are you having or have had difficulty conceiving?

Are your menses regular or irregular?

Is your flow heavy or light?

How many days does your period last?

How many days between periods?

Do you experience any of the following symptoms before or during your period?

_____abdominal cramps	_____food cravings	_____breast tenderness/swelling
_____headaches/migraines	_____depression	_____moodiness
_____dull pain	_____sharp pain	

For Men ONLY:

Do you experience any of the following?

_____swollen testes	_____testicular pain	_____impotence

_____coldness or numbness in genitalia

Other:

_____ _____

Patient's Signature Date