Acupuncture Back Bay
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Name _____ Phone _____ DOB _____
Address _____ City _____ State_____ Zip _____
E-mail _____ Occupation _____
Height _____ Weight _____

Major Complaints

Complaint 1: _____ Date of Onset _____
What makes it better? _____
What makes it worse? _____
Is your condition: ☐Getting Worse ☐Constant ☐Getting Better ☐Off and On

Complaint 2: _____ Date of Onset _____
What makes it better? _____
What makes it worse? _____
Is your condition: ☐Getting Worse ☐Constant ☐Getting Better ☐Off and On

Complaint 3: _____ Date of Onset _____
What makes it better? _____
What makes it worse? _____
Is your condition: ☐Getting Worse ☐Constant ☐Getting Better ☐Off and On

Other complaints: _____

Please list all prescription and OTC medications you are currently taking: _____

Please list all supplements (vitamins, herbs, etc.) you are currently taking: _____

Please list any surgeries/operations you have had and their dates: _____

List all scars from accidents and surgeries: _____

Date of your last physical exam: _____ By whom? _____

Medical History

Please mark anything you have or have previously had

☐Arthritis	☐Epilepsy	☐Chronic Fatigue
☐Asthma	☐Stroke	☐Hepatitis
☐Anemia	☐Kidney/Bladder Trouble	☐Jaundice
☐Heart Trouble	☐Gallstones	☐Sudden Weight Loss
☐Cancer	☐Ulcers	☐Sudden Weight Gain
☐Diabetes	☐High Blood Pressure	

Energy Level: ☐High (time of day?)_____ ☐Low (time of day?) _____
Stress Level: ☐None ☐Moderate ☐Severe -- What causes it? _____
Sweating: ☐Night Sweat ☐Rarely Sweat ☐Excessive Sweating
Circulation: ☐Hot ☐Cold ☐Bleed Easily ☐Cold Limbs Other? _____
What areas? _____
Skin: ☐Dry ☐Itchy ☐Moist/Clammy ☐Burning ☐Changing Moles/Lumps (cysts/tumors) ☐Boils ☐Rashes ☐Acne ☐Hair Loss/Thinning ☐Dry Scalp ☐Skin Puffy/Wrinkled ☐Bruises Easily (black and blue spots) ☐Hives ☐Other: _____
Sleep: ☐Trouble Falling Asleep ☐Trouble Staying Asleep ☐Restful☐ Excessive Dreaming ☐Other: _____
How many hours do you sleep a night? _____
Head: ☐Headaches ☐Dizziness ☐Memory Loss ☐Loss of balance ☐Other: _____

Eyes: ☐Eye Pain ☐Dry Eyes ☐Blurred Vision ☐Darkness Under Eyes ☐Other: _____
Ears: ☐Poor Hearing ☐Earaches ☐Ear Discharge/Infections ☐Frequent Colds ☐Other: _____
Nose: ☐Frequent Nose Bleeds ☐Sinus Trouble/Infections ☐Frequent Colds ☐Other: _____

Please list any allergies you have: _____

Throat: ☐Sore Throat ☐Hoarseness ☐Difficulty Swallowing ☐Jaw Problems (grinding/TMJ) ☐Teeth/Gum Problems ☐Swollen Tongue/Glands ☐Other: _____
Lungs: ☐Asthma ☐Wheezing ☐Shortness of Breath ☐Mucus Rattles When Breathing ☐Trouble Breathing at Night ☐Frequent Cough/Chest Colds ☐Pneumonia ☐Persistent Cough ☐Coughing Phlegm ☐Other
Heart: ☐Heart Attack ☐Stroke ☐Chest Pain/Pressure ☐Palpitations ☐Other: _____
Blood Pressure: ☐High ☐Low ☐Normal ☐I Don't Know
Cholesterol: ☐High ☐Low Levels: _____
Appetite: ☐Normal ☐Excessive Appetite ☐Poor Appetite ☐Appetite Keeps Changing ☐Feel Tired/Week If a Meal Is Missed ☐Food Cravings If so, what? _____
Recent Weight Changes ☐Yes ☐No ☐Other: _____
Nutrition: ☐Skip Breakfast ☐Eat Snacks ☐Eat Hearty Breakfasts ☐Eat When Worried/Rushed
When is your biggest meal? _____ How many meals do you eat? _____
List some of your favorite foods _____
Thirst: ☐Normal ☐Excessive ☐Never Thirsty ☐Other: _____
How much water do you drink per day? _____
Do you drink alcohol ☐Daily ☐Socially ☐Seldom ☐Never Amount Per Week: _____
Digestion: ☐Acid Reflux ☐Belching Stomach Pain or Bloating ☐Gas ☐Nausea ☐Vomit ☐Bad Breath ☐Mouth Sores ☐Bitter/Sour Taste in Mouth ☐Abdominal Bloating (if so, how long after eating?)_____
Food Allergies: ☐Yes ☐No If so, what? _____
Bowels: ☐Diarrhea ☐Constipation ☐Bloody Stools ☐Black Stools ☐Mucus in Stools ☐Hemorrhoids ☐Lower Bowel gas ☐Stools Have Foul Odor ☐Colon Problems
Number of Bowel Movements Per Day? _____
Urine: ☐Frequent Urination ☐Strong Smelling Urine ☐Difficult to Urinate ☐Pain or Burning During Urination ☐Blood in Urine ☐Frequent Infections (bladder/UTI/Kidney) ☐Water Retention
Color: _____ Times per Day _____ (6 is considered average)
Musculoskeletal: ☐Neck Pain ☐Shoulder Pain ☐Pain Between Scapula ☐Arms/Hand Pain ☐Finger Pain ☐Hip Pain ☐Knee Pain ☐Ankle Pain ☐Foot Pain ☐Toe Pain ☐Upper Back Pain ☐Middle Back Pain ☐Lower Back Pain ☐Sore/Painful Bones ☐Loss of Grip ☐Swollen Knees/Elbows ☐Leg Cramps at Night ☐Weakness in Legs ☐Weak Ankles ☐Stiff ☐Tingling in Feet ☐Muscle Spasms/Cramps ☐Loss of Feeling in Hands/Feet ☐Painful Joints ☐Brusitis ☐Other: _____
Neurological: ☐Nervousness ☐Depressed ☐Easily Angered ☐Easily Irritated Frequent Crying ☐Anxiety ☐Panic Attacks ☐Mood Swings ☐Memory Confusion ☐Poor Concentration ☐Suicidal ☐Tremors ☐Numbness in Limbs ☐Poor Coordination ☐Muscle Weakness ☐Weak and Shaky ☐Seizures ☐Neuralgia (nerve Pain) ☐Shingles ☐Other: _____
Females: Pregnant? ☐Yes ☐No Last Monthly Cycle _____ Last PAP Test _____
Form of Birth Control _____ ☐None
Age Started Menstrual Cycle _____ Age Stopped _____ Length of Cycle _____
☐Irregular ☐Menstrual Pain ☐Low Backache ☐Clotting ☐Heavy Bleeding ☐Light/Scanty Bleeding ☐Bloating ☐Mood Changes ☐Miss Periods ☐Low/No Sex Drive ☐Painful Breasts ☐Hot flashes ☐Food Cravings Color: _____ Other: _____
Discharge: ☐Yellow ☐White ☐Thick ☐Odor ☐Itching ☐Liquid
# of Pregnancies: _____# of Deliveries _____# of Miscarriages _____#of Abortions_____
Males: ☐Low/No Sex Drive ☐Impotence ☐Ejaculation Causes Pain ☐Discharge ☐Pain/Burning While Urinating ☐Premature Ejaculation ☐Difficulty Starting/Stopping Urine ☐Prostate Trouble ☐Other

Patient Signature: _____ Date _____