Acupuncture

Name Date

Address

Work Phone | Home Phone

E-mail Address | Sex Age

Date of Birth | Height Weight

Occupation hrs at job per week Marital Status

Physician Name

Emergency Contact name and number

Main Complaint:

Please circle any of the following that you have been diagnosed with at any time during your life:

Asthma	Drug/Alcohol Abuse	High Blood Pressure/Cholesterol	Multiple Sclerosis
Cancer	Heart Disease	HIV/AIDS	Stomach Ulcers
Diabetes	Hepatitis	Mental Disorder /Emotional Trauma	Stroke /Thyroid Dis.

Do you Smoke, if so how often

Drugs Herbs or supplements that you have taken within the last three months

How would you rate your daily stress level – rate from 1-10,_____ (10 being highest) energy level _____

Number of Pregnancies Live Births

How would you describe your typical diet: do you use caffeine, sugar, salt, artificial sweetener, list cravings or residual tastes in the mouth.

Please describe any problems you are currently experiencing with :

Sleep/insomnia/nightmares

Digestion/bowels movements/ urination

Mouth/ throat / ears/eyes

Skin/allergies

Headaches/dizziness

Menstruation/menopause/libido

Emotions/ ability to handle stress

Pain/ cardio/circulation

Codes used:

Tongue

Pulse R

L

DX

TX

Points and tx used

HERBS