MAPLEBROOK COMMUNITY ACUPUNCTURE CLINIC

6703 E 81st Street Suite J
Tulsa, OK 74133
(918) 814-7650

PATIENT INFORMATION	CONTACT INFORMATION
Date: _____	Home phone: _____
Name: _____	Work Phone: _____
Address: _____	Other/Cell Phone: _____
City, State, Zip: _____	Email: _____
DOB: _____	Marital Status: _____
Occupation: _____	
Primary Physician: _____	Emergency Contact: _____
Physician phone number: _____	Phone number: _____
How did you Hear about us? _____	Who Referred You: _____
Have you received acupuncture therapy before? _____	_____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1. _____
2. _____
3. _____

How is your sleep? _____
How is your digestion? _____
(# of bowel movement times/week)
_____

List medications, supplements you are taking:

_____
_____
_____

List serious illnesses, accidents or surgeries

_____
_____
_____

Check illnesses that have occurred in blood relatives.

____ Diabetes ___ High blood pressure ___ Stroke

___ Cancer ____ Heart disease ____ Kidney disease

Check symptoms you have or have had in the last year:

- ○ Depression
- ○ Difficulty in focusing
- ○ Dizziness
- ○ Easily startled
- ○ Excessive worry
- ○ Excessive anger
- ○ Excessive fear
- ○ Fatigue/tiredness
- ○ Headaches
- ○ Loss of sleep/poor sleep
- ○ Loss or gain of weight
- ○ Nervousness/irritability
- ○ Overwhelmed by life
- ○

How long has it been since you have had a complete medical exam?

_____

MUSCLE/JOINT/BONES

- Tremors
- Cramps
- Swollen Joints

Pain, weakness, numbness in:

- Neck
- Shoulders
- Arms
- Hands
- Back
- Hips
- Legs
- Feet
- Other _____

CARDIOVASCULAR

- Chest Pain
- Hardening of arteries
- High or Low Blood Pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of Hearing
- Persistent cough
- Ringing in ears
- Sinus problems

GASTROINTESTIANAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual flow
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant?

_____

Indicate with a one (1) any condition that you sometimes experience, two (2) for those which occur often, and three (3) for symptoms that are a major concern.

Water Element	Wood Element	Fire Element	Metal Element	Earth Element
__ Hearing loss	__ Headaches	__ Dry Scalp	__ Bronchitis	__Underweight
__ Dizziness	__ Migraines	__ Skin rash	__ Asthma	__ Indigestion
__ Low back Pain	__Ringing in ears	__ Cysts/tumor	__ Weak breath	__ Flatulence
__ Neck Pain	__ Poor eyesight	__ Ear infection	__ Cough	__ Food allergy
__ Sinus congestion	__Eye infection	__ Sore throat	__ Sinus problem	__ Stomachache
__ Edema	__ Dry eyes	__ Lymph swelling	__ Allergies	__ Ulcer
__ Dark under eyes	__ Eczema	__ Hot palms/soles	__ Nose infection	__ Diarrhea
__ Emotional instability	__ Shingles	__ Heart palpitations	__ Grief/Weeping	__ Anemia
__ Aversion to cold	__Herpes simplex	__ Aversion to heat	__ Skin problems	__ Halitosis
__ Hair thinning/loss	__ Warts	__ Bitter taste in mouth		__ Mouth sores
__ Premature aging	__ Nervousness	__ Gum problems		__ Heartburn
__Frequent urination	__Convulsion	__ Nose bleed		__ Big appetite
__ Kidney stones	__ Spasms	__ Facial redness		__ Weak appetite
__ Perspire easily	__ Irritability	__ Itch/burn skin		__ Abd. Bloating
__ Weak legs/knees	__ Constipation	__ Thirst		__ Excess worry
__ Asthmatic cough	__ Hemorrhoids	__ Vivid dreaming		__ Obsessive
__ Rapid weight change	__ Hepatitis	__ Dark urine		__ Acid reflux
__ Loose teeth/loss	__ Ulcer	__ Night sweats		
__Reduced sexual energy	__ Vomiting	__ Excess Joy	**Other**	
__ Thyroid problems	__Gallstones		__ Fatigue	
__ Diabetes	__ Indecisive		__ Arthritis	
__ Excess fear	__ Fullness below ribs		__ Sciatica	
__Hearing problems	__ Shoulder tension		__ Nerve pain	
	__ Neck tension		__ Cold hands/feet	
	__ Insomnia 11pm-3am		__Bursitis/tendonitis	

FOR WOMEN ONLY (check all that apply)

Are you pregnant? ___ # of children ___ # of miscarriage ___ # of abortion ___
Pregnancy complications? _____
Any menstrual difficulties? _____

Menstrual cycle	Vaginal discharge	Gynecology History
__ Irregular	__ Liquid	__ Overies _____
__ Painful	__ Yellow	__ Tubes _____
__ Excess/Deficient bleeding	__ Thick	__ Vagina _____
__ Water retention	__ Bad odor	__ Breast _____
__ Dark/light color	__ White	
__ Painful breast	__ Other	__ Other _____
__ Heavy clots		
__ Feel better before menstrual flow		
__ Feel better after menstrual flow	Any other comments: _____	

FOR MEN ONLY (check all that apply)

__ Reduced sexual energies
__ Premature ejaculation
__ Seminal emission
__ Other _____
__ Pain with urination
__ Prostate problems
__ Impotence
__ Groin Pain
__ Infertility

What type of care do you desire?

	Temporary relief of symptoms/pain control
	Eradication of tendencies causing your condition
	Balanced optimum health-care, elimination of root cause of problem, if possible
	Maintenance care/balance to stay in good health.

How would you classify your condition? __ Minor __ Severe/worsening __ involved __ serious

On a scale of 1-10, how would you rate how your health problem affects your life?

(1 is no problem, 10 is major problem) _____

List one adjective/word to describe your life: _____

NOTES: _____

_____

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