



## MAPLEBROOK COMMUNITY ACUPUNCTURE CLINIC

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 (918) 814-7650

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

HEALTH HISTORY
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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	<p style="text-align: center;"><u><i>Check symptoms you have or have had in the last year:</i></u></p> <ul style="list-style-type: none"> <li><input type="radio"/> Depression</li> <li><input type="radio"/> Difficulty in focusing</li> <li><input type="radio"/> Dizziness</li> <li><input type="radio"/> Easily startled</li>   <li><input type="radio"/> Excessive worry</li> <li><input type="radio"/> Excessive anger</li> <li><input type="radio"/> Excessive fear</li> <li><input type="radio"/> Fatigue/tiredness</li> <li><input type="radio"/> Headaches</li> <li><input type="radio"/> Loss of sleep/poor sleep</li> <li><input type="radio"/> Loss or gain of weight</li> <li><input type="radio"/> Nervousness/irritability</li> <li><input type="radio"/> Overwhelmed by life</li> <li><input type="radio"/></li> </ul> How long has it been since you have had a complete medical exam? _____
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MUSCLE/JOINT/BONES	CARDIOVASCULAR	
<ul style="list-style-type: none"> <li>○ Tremors</li> <li>○ Cramps</li> <li>○ Swollen Joints</li> </ul> <p style="text-align: center;"><u><i>Pain, weakness, numbness in:</i></u></p> <ul style="list-style-type: none"> <li>○ Neck</li> <li>○ Shoulders</li> <li>○ Arms</li> <li>○ Hands</li> <li>○ Back</li> <li>○ Hips</li> <li>○ Legs</li> <li>○ Feet</li> <li>○ Other _____</li> </ul>	<ul style="list-style-type: none"> <li>○ Chest Pain</li> <li>○ Hardening of arteries</li> <li>○ High or Low Blood Pressure</li> <li>○ Pain over heart</li> <li>○ Poor circulation</li> <li>○ Previous heart attack</li> <li>○ Rapid/irregular heart beat</li> <li>○ Swelling of ankles</li> </ul>	
EYES/EAR/NOSE/THROAT/RESPIRATORY	GASTROINTESTIANAL	
<ul style="list-style-type: none"> <li>○ Asthma/wheezing</li> <li>○ Blurred or failing vision</li> <li>○ Difficulty breathing</li> <li>○ Earache</li> <li>○ Enlarged glands</li> <li>○ Eye pain</li> <li>○ Frequent colds</li> <li>○ Hay fever</li> <li>○ Hoarseness</li> <li>○ Gum trouble</li> <li>○ Nose bleeds</li> <li>○ Loss of Hearing</li> <li>○ Persistent cough</li> <li>○ Ringing in ears</li> <li>○ Sinus problems</li> </ul>	<ul style="list-style-type: none"> <li>○ Belching, gas or bloating</li> <li>○ Colon trouble</li> <li>○ Constipation</li> <li>○ Diarrhea</li> <li>○ Difficulty swallowing</li> <li>○ Distention of abdomen</li> <li>○ Excessive hunger</li> <li>○ Gall bladder trouble</li> <li>○ Hemorrhoids (piles)</li> <li>○ Indigestion</li> <li>○ Nausea</li> <li>○ Pain over stomach</li> <li>○ Poor appetite</li> <li>○ Vomiting</li> </ul>	
	FOR MEN ONLY	
<th data-bbox="94 1356 813 1404" style="text-align: center;">SKIN</th>	SKIN	<ul style="list-style-type: none"> <li>○ Erection difficulties</li> <li>○ Penis discharge</li> <li>○ Prostate trouble</li> </ul>
	FOR WOMEN ONLY	
<th data-bbox="94 1686 813 1734" style="text-align: center;">GENITO/URINARY</th>	GENITO/URINARY	<ul style="list-style-type: none"> <li>○ Bleeding between periods</li> <li>○ Clots in menses</li> <li>○ Excessive menstrual flow</li> <li>○ Extreme menstrual flow</li> <li>○ Irregular cycle</li> <li>○ Menopausal symptoms</li> <li>○ PMS</li> <li>○ Previous miscarriage</li> <li>○ Scanty menstrual flow</li> </ul> <p>Could you be pregnant?</p>

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
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dry Scalp	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Underweight
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Migraines	<input type="checkbox"/> Skin rash	<input type="checkbox"/> Asthma	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Low back Pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Cysts/tumor	<input type="checkbox"/> Weak breath	<input type="checkbox"/> Flatulence
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Poor eyesight	<input type="checkbox"/> Ear infection	<input type="checkbox"/> Cough	<input type="checkbox"/> Food allergy
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Eye infection	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Sinus problem	<input type="checkbox"/> Stomachache
<input type="checkbox"/> Edema	<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Lymph swelling	<input type="checkbox"/> Allergies	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Dark under eyes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hot palms/soles	<input type="checkbox"/> Nose infection	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Emotional instability	<input type="checkbox"/> Shingles	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Grief/Weeping	<input type="checkbox"/> Anemia
<input type="checkbox"/> Aversion to cold	<input type="checkbox"/> Herpes simplex	<input type="checkbox"/> Aversion to heat	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Halitosis
<input type="checkbox"/> Hair thinning/loss	<input type="checkbox"/> Warts	<input type="checkbox"/> Bitter taste in mouth	<input type="checkbox"/> Lost someone	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Premature aging	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Gum problems		<input type="checkbox"/> Heartburn
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Convulsion	<input type="checkbox"/> Nose bleed		<input type="checkbox"/> Big appetite
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Spasms	<input type="checkbox"/> Facial redness		<input type="checkbox"/> Weak appetite
<input type="checkbox"/> Perspire easily	<input type="checkbox"/> Irritability	<input type="checkbox"/> Itch/burn skin		<input type="checkbox"/> Abd. Bloating
<input type="checkbox"/> Weak legs/knees	<input type="checkbox"/> Constipation	<input type="checkbox"/> Thirst		<input type="checkbox"/> Excess worry
<input type="checkbox"/> Asthmatic cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Vivid dreaming		<input type="checkbox"/> Obsessive
<input type="checkbox"/> Rapid weight change	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Dark urine		<input type="checkbox"/> Acid reflux
	<input type="checkbox"/> Ulcer			
	<input type="checkbox"/> Anger			
	<input type="checkbox"/> Depression	<input type="checkbox"/> Night sweats		<input type="checkbox"/> Overthinking
<input type="checkbox"/> Loose teeth/loss	<input type="checkbox"/> Frustration	<input type="checkbox"/> Excess Joy		
<input type="checkbox"/> Reduced sexual energy	<input type="checkbox"/> Vomiting		<b>Other</b>	<input type="checkbox"/> Worry
	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Joy	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Butterflies in Stomach
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Indecisive	<input type="checkbox"/> Sadness	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fullness below ribs	<input type="checkbox"/> Crying	<input type="checkbox"/> Sciatica	
<input type="checkbox"/> Excess fear	<input type="checkbox"/> Shoulder tension		<input type="checkbox"/> Nerve pain	
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Neck tension		<input type="checkbox"/> Cold hands/feet	
<input type="checkbox"/> Fear	<input type="checkbox"/> Insomnia 11pm-3am		<input type="checkbox"/> Bursitis/tendonitis	
<input type="checkbox"/> Shock				

**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
<input type="checkbox"/> Irregular <input type="checkbox"/> Painful <input type="checkbox"/> Excess/Deficient bleeding <input type="checkbox"/> Water retention <input type="checkbox"/> Dark/light color <input type="checkbox"/> Painful breast <input type="checkbox"/> Heavy clots <input type="checkbox"/> Feel better before menstrual flow <input type="checkbox"/> Feel better after menstrual flow	<input type="checkbox"/> Liquid <input type="checkbox"/> Yellow <input type="checkbox"/> Thick <input type="checkbox"/> Bad odor <input type="checkbox"/> White <input type="checkbox"/> Other Any other comments: _____	<input type="checkbox"/> Ovaries _____ <input type="checkbox"/> Tubes _____ <input type="checkbox"/> Vagina _____ <input type="checkbox"/> Breast _____ <input type="checkbox"/> Other _____

**FOR MEN ONLY** (check all that apply)

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

**What type of care do you desire?**

<input type="checkbox"/>	Temporary relief of symptoms/pain control
<input type="checkbox"/>	Eradication of tendencies causing your condition
<input type="checkbox"/>	Balanced optimum health-care, elimination of root cause of problem, if possible
<input type="checkbox"/>	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: \_\_\_\_\_

How is your pain level today?



Notes:

\_\_\_\_\_