Gaiatree Acupuncture
& Chinese Medicine

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TRADITIONAL CHINESE MEDICINE
PATIENT INFORMATION

This form is strictly confidential.

Name: _____ Today's Date: _____

Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email:_____ Preferred method of contact: ❑ Cell ❑ Home ❑ Work

Date of Birth: _____ Age: _____ Gender: ❑ Female ❑ Male

Emergency Contact: _____ Emergency Phone #: _____

Primary Physician:_____ Physician Phone #: _____

Occupation _____ Marital Status: _____

How did you hear about me? _____

Are you currently taking any medication/drugs/herbs/supplements: ❑ Yes ❑ No

If yes, please specify: _____

_____

_____

Do you have a family history of any of the following conditions:

❑ Diabetes ❑ High Blood Pressure ❑ Stroke ❑ Cancer ❑ Heart Disease

❑ Kidney Disease ❑ Other _____

Check the conditions you have been diagnosed with currently or in the past:

❑ Anemia	❑ Arthritis	❑ Asthma	❑ Bleeding Disorder
❑ Cancer	❑ Diabetes	❑ Head Trauma	❑ Heart Disease
❑ Hepatitis (type____)	❑ High Blood Pressure	❑ HIV/AIDS	❑ Immune Disorders
❑ Pacemaker	❑ Seizures	❑ Stroke	❑ Thyroid Disorder

❑ Other Please specify: _____

Are you pregnant: ❑ Yes ❑ No Are you trying to conceive: ❑ Yes ❑ No

Have you received acupuncture before: ❑ Yes ❑ No

Main Complaint: _____

_____

_____

Date of onset: _____ How long have you had this condition: _____

Have you had this in the past: ❑ Yes ❑ No When:_____

Is this condition: ❑ Improving ❑ Constant ❑ Getting Worse ❑ Intermittent

What makes it feel better: ❑ Heat ❑ Cold ❑ Movement ❑ Rest ❑ Don't Know ❑ Other

Please specify: _____

_____

What makes it feel worse: ❑ Heat ❑ Cold ❑ Movement ❑ Rest ❑ Don't Know ❑ Other

Please specify: _____

_____

Is the pain: ❑ Mild ❑ Moderate ❑ Severe

On a scale from 1 (best) to 10 (worse) the pain is_____

Have you had a Western medical exam for this condition & when? _____

What diagnosis have you been given? _____

What other forms of treatment have you tried? _____

_____

List serious accidents or surgeries with the date included? _____

_____

_____

_____

_____

HEALTH HISTORY CONTINUED: Please check symptoms you have or have had in the past year.

Emotions/Energy
- ❑ Low energy
- ❑ Difficulty in focusing
- ❑ Dizziness
- ❑ Easily startled
- ❑ Excessive worry
- ❑ Often feel angry or irritated
- ❑ Poor sleep
- ❑ Loss or gain in weight
- ❑ Symptoms worsen with stress
- ❑ Poor memory
- ❑ Nervousness/ anxiety
- ❑ Feel sad a lot
- ❑ Mood swings
- ❑ Depression
- ❑ Indecisive

General Temperature
- ❑ Spontaneous sweating
- ❑ Hot body temperature
- ❑ Cold body temperature
- ❑ Aversion to heat or cold
- ❑ Fever or chills
- ❑ Cold hands & feet
- ❑ Hot flashes
- ❑ Night sweats
- ❑ Lack of sweating

Skin
- ❑ Rash
- ❑ Itching
- ❑ Bruise easily
- ❑ Slow wound healing
- ❑ Acne, boils
- ❑ Hives
- ❑ Dry skin

Head, Ear, Eyes, Nose, Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Jaw pain/TMJ
- ❑ Decreased hearing
- ❑ Ringing in ears
- ❑ Floaters (spots in front of eyes)
- ❑ Poor night vision
- ❑ Double or blurred vision
- ❑ Eye pain/ strain
- ❑ Tearing or dryness
- ❑ Itchy eyes, red, inflamed eyes
- ❑ Sinus problems
- ❑ Runny nose
- ❑ Loss of smell
- ❑ Teeth problems
- ❑ Mouth ulcers or sores on tongue
- ❑ Bleeding gums
- ❑ Bad breath
- ❑ Dry mouth
- ❑ Oral thrush
- ❑ Sore throat

Respiratory
- ❑ Cough
- ❑ Asthma
- ❑ Wheezing
- ❑ Difficulty breathing
- ❑ Production of phlegm
- ❑ Frequent colds/ sinus infections
- ❑ Allergies

Muscle/Joint/Bones
- ❑ Pain
- ❑ Weakness
- ❑ Numbness
- ❑ Tremors or spasms
- ❑ Cramps
- ❑ Swollen joints

Where? _____
_____

Digestion
- ❑ Nausea
- ❑ Low appetite
- ❑ Belching, gas or bloating
- ❑ Tired after eating
- ❑ Constipation
- ❑ Diarrhea/loose stool
- ❑ Undigested food in stool
- ❑ Excessive hunger
- ❑ Indigestion
- ❑ Acid reflux/ heartburn
- ❑ Stomach pain
- ❑ Feeling of heaviness in body
- ❑ Hemorrhoids
- ❑ Blood or mucus in stool

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ High cholesterol
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Fainting
- ❑ Swelling of the ankles
- ❑ Poor circulation
- ❑ Previous heart attack
- ❑ Palpitations

Sleep
- ❑ Poor sleep
- ❑ Difficult falling asleep
- ❑ Restless sleep
- ❑ Wake too early, what time? _____
- ❑ Feel hot or sweaty at night
- ❑ Excessive Dreams
- ❑ Waking up not rested

Average hrs of sleep per night: _____

Urinary Tract
- ❑ Frequent urination
- ❑ Frequent night urination
- ❑ Poor bladder control
- ❑ Frequent infection
- ❑ Kidney stones

Urine Description
- ❑ Painful
- ❑ Clear
- ❑ Scanty
- ❑ Strong smell
- ❑ Dark
- ❑ Cloudy
- ❑ Profuse
- ❑ Urgent

Lifestyle
- ❑ Vegetarian
- ❑ Eat a lot of fried foods
- ❑ Eat a lot of meat
- ❑ Eat a lot of sweets
- ❑ Healthy/ conscious diet
- ❑ Smoke
- ❑ Drink alcohol, amount per wk?

_____
- ❑ Drink coffee, amount per day?

_____
- ❑ Exercise regularly, how often?

_____

For Men
- ❑ Prostate trouble
- ❑ Testicular pain/swelling
- ❑ Penis discharge
- ❑ Fertility/ erection difficulties
- ❑ Decreased libido

For Women
- ❑ Peri-menopause
- ❑ Completed menopause
- ❑ Partial/ total hysterectomy
- ❑ Decreased libido
- ❑ Bleeding between periods
- ❑ PMS
- ❑ Clots in menses
- ❑ Menstrual cramps/ pain
- ❑ Excessive menstrual flow
- ❑ Heavy periods
- ❑ Scanty periods
- ❑ Breast lumps
- ❑ Uterine fibroids
- ❑ Chronic vaginal infections

Period lasts _____ days.
_____ days between periods.
How many Pregnancies? _____
- ❑ Previous miscarriage

Could you be pregnant? _____