



# BLESSING ACUPUNCTURE

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## Patient Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred method of contact:  Work  Home  Email

Date of Birth: \_\_\_\_\_ Gender:  Female  Male

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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:

Cancer  Diabetes  Allergies  Heart Disease  High Blood Pressure  Stroke  Other

Please specify: \_\_\_\_\_

Have you ever had or do you currently suffer from any of the following conditions:

Cancer  Diabetes  Allergies  Heart Disease  High Blood Pressure  Stroke  Hepatitis  AIDS  
 High Cholesterol  Asthma  Thyroid disorder  Diabetes  Immune disorders  Other

Please specify: \_\_\_\_\_

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

### For insurance purposes only:

Name of Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Member ID: \_\_\_\_\_ Employer: \_\_\_\_\_

**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

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\_\_\_\_\_

**Supplemental Information:**

|   |  |
|---|--|
| <p><b>Energy level</b><br/><input type="checkbox"/>High (time of day)_____</p> <p><input type="checkbox"/>Low (time of day)_____</p> <p><input type="checkbox"/>Feel sleepy after eating</p> <p><b>Temperature</b><br/><input type="checkbox"/>Feel cold easily</p> <p><input type="checkbox"/>Cold feet (time of day) _____</p> <p><input type="checkbox"/>Cold hands(time of day)_____</p> <p><input type="checkbox"/>Chills</p> <p><input type="checkbox"/>Feel hot easily</p> <p><input type="checkbox"/>Hot flashes (time of day) _____</p> <p><input type="checkbox"/>Burning sensation in <input type="checkbox"/>palms <input type="checkbox"/>feet<input type="checkbox"/>chest</p> <p><input type="checkbox"/>Fever (how high) _____</p> <p><input type="checkbox"/>Low grade fever (for how long)_____</p> <p><input type="checkbox"/>Alternating Hot and Cold<br/>(noticeable temperature swings)</p> <p><b>General:</b><br/><input type="checkbox"/>Weight gain</p> <p><input type="checkbox"/>Weight loss</p> <p><input type="checkbox"/>Edema</p> <p><input type="checkbox"/>Excess thirst</p> <p><input type="checkbox"/>Lack of thirst</p> <p><input type="checkbox"/>Hair loss</p> <p>Crave: <input type="checkbox"/>sweet <input type="checkbox"/>salty <input type="checkbox"/>sour <input type="checkbox"/>spicy foods</p> | <p><b>Sleep</b><br/><input type="checkbox"/>Restful</p> <p><input type="checkbox"/>Dream-disturbed</p> <p><input type="checkbox"/>Nightmares</p> <p><input type="checkbox"/>Insomnia: <input type="checkbox"/>Difficult falling asleep <input type="checkbox"/>staying asleep</p> <p>How many hours do you sleep each night:<br/>_____</p> <p><b>Digestion/Gastrointestinal</b><br/><input type="checkbox"/>Belching <input type="checkbox"/>Gas <input type="checkbox"/>Bad breath <input type="checkbox"/>Bloating</p> <p><input type="checkbox"/>Nausea <input type="checkbox"/>Vomitting</p> <p><input type="checkbox"/>Diarrhea</p> <p><input type="checkbox"/>Loose stools</p> <p><input type="checkbox"/>Constipation</p> <p><input type="checkbox"/>Undigested food in stool</p> <p><input type="checkbox"/>Heart burn <input type="checkbox"/>Ulcers <input type="checkbox"/>Indigestion</p> <p><input type="checkbox"/>Excess hunger</p> <p><input type="checkbox"/>Low appetite <input type="checkbox"/>No appetite</p> <p><input type="checkbox"/>Abdominal pain (when is it worse: <input type="checkbox"/>After eating<br/><input type="checkbox"/>Before eating)</p> <p><input type="checkbox"/>Rectal Pain <input type="checkbox"/>Hemorrhoids</p> <p><input type="checkbox"/>Rectal Bleeding: <input type="checkbox"/>Red <input type="checkbox"/>Brown <input type="checkbox"/>Black</p> <p><input type="checkbox"/>Mucus in stool</p> <p>How often do you have a bowel movement:<br/>_____</p> <p>Stool is: <input type="checkbox"/>Dry <input type="checkbox"/>Hard <input type="checkbox"/>Loose <input type="checkbox"/>Pebble-like<br/><input type="checkbox"/>Urgent <input type="checkbox"/>Watery <input type="checkbox"/>Other_____</p> |
|---|--|

**Head & Neck**

Headaches (where) \_\_\_\_\_

How often: \_\_\_\_\_

Cause: \_\_\_\_\_

- Dizziness Vertigo
- Blurred vision Eye pain Floaters
- Memory loss
- Poor coordination
- Seizures
- Tingling Numbness Tremors (where)

**Sweating**

- Sweat easily without much activity
- Hardly ever sweat
- Night sweat
- Profuse sweating
- Sweating of hands and feet

**Ear/Nose/Throat/Mouth**

- Sinus congestion Runny nose Sneezing
- Frequent colds Sore throat Infections
- Nose bleeding
- Ringing in the ears: (sound) Low High
- Blocked ear Ear pain
- Loss of hearing
- Bleeding Gums
- Grinding teeth

**Chest/Respiration**

- Shortness of Breath Wheezing
- Dry cough: Day Night Persistent
- Productive cough: (phlegm) Thin Thick
- Color: \_\_\_\_\_
- Chest pain Ribsides pain
- Palpitations

**Urination**

- Frequent urination: Day Night
- Burning urination Blood in the urine
- Difficult urination Dribbling
- Urgent Incontinence
- Frequent urinary tract infections

**Emotions**

- Nervous Depressed Anxious
- Easily angered Easily irritated
- Moody Manic
- Crying easily
- Fearful Grieving

**Lifestyle**

Do you:

- Smoke Drink coffee Tea(cups/day): \_\_\_\_\_
- Drink alcohol:(glass/wk \_\_\_\_\_)
- Exercise(type/frequency): \_\_\_\_\_

**Female Health**

- Date of last menstrual period \_\_\_\_\_
- Menses lasts \_\_\_\_\_ days
- Duration of cycle \_\_\_\_\_ days
- Do you menstruate regularly: Yes No
- Color: Pale red Bright red Dark Brown
- Consistency: Thick Watery
- Clotting: Yes No
- Cramps
- (better with) Heat Exercise Rest
- Breast tenderness
- Acne Mood changes Food cravings
- Bearing down sensation
- Low Back pain
- Spotting between periods
- Menopause
- Hot flashes
- Vaginal dryness
- Libido: Low High