Sue Foss
East Asian Medicine Practitioner



## Personal Details

Date: _____

First Name: _____ MI: _____ Last Name: _____

Preferred Phone: _____ Other Phone: _____

Email: _____

Mailing Address: _____
Street City State Zip

Contact in case of emergency: _____ Contact Phone: _____

Primary Care Physician: _____

Referred by: _____ Have you had acupuncture before? _____

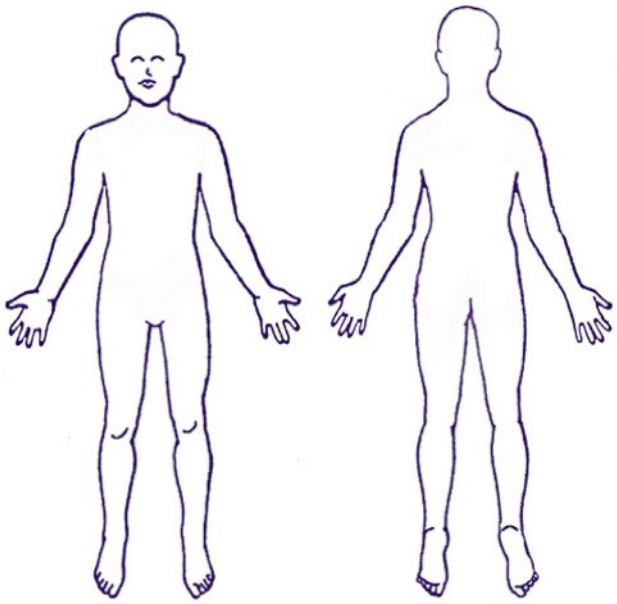
Age: _____ Date of Birth: _____ Height: _____ Weight: _____ Occupation: _____

Please list reason for your appointment today from most to least important.

1. _____ How Long? _____

2. _____ How Long? _____

Please indicate problem areas:



Other types of treatment you have tried: _____

## Personal Details

List any medications, herbs, or supplements taken on a regular basis: _____

_____

Surgeries or significant trauma (auto accidents, falls, etc. Please list type and date): _____

_____

_____

Please describe your typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Allergies, food sensitivities, or dietary restrictions: _____

_____

_____

_____

_____ # of caffeinated beverages daily _____ # of alcoholic beverages per week _____ # of glasses of water per day

Do you use tobacco? ☐Yes / ☐No Do you have a pacemaker? ☐Yes / ☐No Do you have a bleeding disorder? ☐Yes / ☐No

Describe exercise and relaxation activities: _____

_____

_____

_____

## Additional Information

Does your health history include any of the following?

☐ Diabetes ☐ Thyroid disorder ☐ Blood clots ☐ Seizures ☐ Hepatitis

☐ Cancer - date/type _____

Please check any of the following that you have experienced in the past 3 months:

### Temperature

☐ often feel warm
☐ often feel cold
☐ cold feet and hands
☐ sweating easily without exertion
☐ rarely sweat
☐ night sweats

### Digestive

☐ appetite low/high
☐ gas
☐ bloating
☐ stomach pain
☐ nausea
☐ diarrhea
☐ constipation
☐ loose stool
☐ undigested food in stool
☐ acid reflux

### Sleep

_____ # of hours per night
☐ longer than 30 min to fall asleep
☐ apnea

### Urinary

☐ frequent urination
☐ getting up at night to urinate
☐ painful urination
☐ recurrent infections

### Eyes

☐ spots in visual field
☐ blurry vision
☐ dry eyes

### Head/Ears/Nose/Throat

☐ headaches
☐ dizziness
☐ ear ringing
☐ hearing loss
☐ sinus problems
☐ chronic colds/flu
☐ hayfever/allergies
☐ chronic sore throats

### Cognitive/Emotional

☐ anxiety
☐ depression
☐ excessive stress
☐ poor memory
other _____

### Heart/Chest

☐ chest pain
☐ heart palpitations
☐ fluttering in chest
☐ trouble breathing deeply
☐ shortness of breath
☐ heart disease
☐ hypertension
☐ poor circulation
☐ high cholesterol
☐ history of stroke
☐ asthma

### Skin/Hair

☐ cold sores
☐ mouth sores
☐ dry skin/hair
other _____

### Energy

☐ sufficient daily energy
☐ morning fatigue
☐ fatigue after eating
☐ general fatigue

### Neuro/Mus/Skeletal

☐ chronic pain
Explain _____
☐ numbness/tingling
☐ muscle cramps
☐ paralysis
☐ weakness in limbs
☐ swelling/edema

### For Women Only

☐ irregular menstruation
_____ # of days in cycle
_____ # of bleeding days
☐ post-menopausal
_____ age of first menses
☐ painful menstruation
☐ PMS
☐ headaches with cycle
other _____
_____ # of pregnancies
w of children _____

_____

*My health and medical information represented here is true and correct to the best of my knowledge.*

_____ _____
*Signature of patient or legal guardian* *Date*