Wei Acupuncture of Newark

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Newark, OH 43055
(740) 334-0485
Fax-(740) 522-0228

Name:______________________________ Date of Birth: ___________ Gender: __________

Address: ______________________City: _______________State: _______ Zip: ___________

Phone Numbers: (home) ________________ (work) _______________ (cell) ______________

Emergency Contact:_________________________ Phone: ____________________________

How did you hear about this clinic? ____

Reason for today's visit: ______________________________________Duration of problem? _________________

☐ Yes, I have been treated by Acupuncture before? Date of last treatment? ___________________________

☐ Yes, I am currently under a physician's care for: ____

Name of Physician: ______________________________________ Phone: _______________________

☐ Yes, I am currently taking prescription drugs.
Drugs currently taking? ____

____

____

____

☐ Yes, I have or have had an infectious disease. Describe: ______________________________________

☐ Yes, I have allergies.

☐ Foods – Describe: ____

☐ Medications – Describe: ____

☐ Bites/stings – Describe: ____

☐ Seasonal changes – Describe: ____

☐ Animals – Describe: ____

Family Medical History (please check all that apply to immediate family members)

☐ AIDS
☐ Alcoholism
☐ Allergies
☐ Asthma
☐ Cancer
☐ Diabetes (I/II)
☐ Heart disease
☐ Hypertension
☐ Seizure
☐ Stroke
☐ Pulmonary Disease
☐ Other
☐ ________________
☐ ________________

Describe:

Mother's Health Challenges:____ Living/Deceased

Father's Health Challenges: ____Living/Deceased

Siblings' Health Challenges ____ Living/Deceased

Of Siblings ____________ Birth Order: ☐ oldest; ☐ middle; ☐ youngest; ☐ adopted

Grandparents Health Challenges: ____Living/Deceased

Personal Health History (please check if any of the following applies)

- ☐ Injuries? ____________________
- ☐ Accidents? ____________________
- ☐ Falls? ____________________
- ☐ Surgeries? List when and for what: ____________________

____

____

- ☐ AIDS
- ☐ Alcoholism
- ☐ Asthma
- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Birth Trauma (yours)
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Endocrine Disorder
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Multiple Sclerosis
- ☐ Thyroid Disease
- ☐ Childhood Fevers
- ☐ Childhood Illnesses
- ☐ Insomnia
- ☐ Other________________ ________________

Current Symptoms (please check if any of the following applies)

- ☐ Headaches
- ☐ Vision problems
- ☐ Jaw/teeth pain
- ☐ Ear pain
- ☐ Sinus pain/problem
- ☐ Breathing difficulties
- ☐ Chest pain
- ☐ Urination difficulties
- ☐ Infertility
- ☐ Impotence
- ☐ Muscular pain
- ☐ Joint dysfunction/pain
- ☐ Blood pressure – low/high
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Skin disorders
- ☐ PMS
- ☐ Menstrual disorders
- ☐ Menopausal problems
- ☐ Anxiety
- ☐ Depression
- ☐ Overly emotional
- ☐ Insomnia

Life Style (please check where appropriate)

- ☐ Live alone
- ☐ Live with spouse/ significant other
- ☐ Roommate
- ☐ Live with parents
- ☐ Live with children
- ☐ Enjoy home
- ☐ Have family support
- ☐ Have financial support
- ☐ Religious
- ☐ Spiritual connection
- ☐ Work
- ☐ Work 1st shift
- ☐ Work 2nd shift
- ☐ Work 3rd shift
- ☐ Work inconsistent hours
- ☐ Manage own business
- ☐ Enjoy work
- ☐ Unemployed
- ☐ Student-full time
- ☐ Student-part time
- ☐ Exercise seldom
- ☐ Exercise occasionally
- ☐ Exercise often
- ☐ Enjoy hobby

Personal Habits (please check where appropriate)

- ☐ Currently use tobacco
  # per day? _________
- ☐ Currently use alcohol
  # drinks per week? __________
- ☐ Recreational drugs
- ☐ Former tobacco use
  # years ago quit? ______
- ☐ Former alcohol use
  # years ago quit? _____

Supplements: (please list all that you are currently taking with dosage)

Herbs:

____

____

Supplements:

____

____

____

____

Diet (please check where appropriate)

- ☐ Mainly red meat
- ☐ Mainly chicken/fish
- ☐ Soy products
- ☐ Vegetarian
- ☐ Variety of vegetables
- ☐ Variety of fruits
- ☐ High grain
- ☐ Dairy
- ☐ Fried foods
- ☐ High carbohydrate
- ☐ Low carbohydrate
- ☐ Low fat
- ☐ Low salt
- ☐ High protein
- ☐ Spicy foods
- ☐ Starches
- ☐ Refined sugar
- ☐ Artificial sugars
- ☐ Water
- ☐ Soda
- ☐ Diet soda
- ☐ Coffee
- ☐ Tea
- ☐ Fruit juice
- ☐ Beer
- ☐ Wine
- ☐ Mixed drinks
- ☐ Cook for self/family
- ☐ Fast food 4x per wk+
- ☐ Eat out 3x per wk+

Please indicate if you have or have ever had any of the following:

Head, Eyes, Ears, Nose Throat

- ☐ Glasses
- ☐ Night blindness
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spot in eyes
- ☐ Spots in vision
- ☐ Blurred vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Nosebleeds
- ☐ Ear ringing
- ☐ Hearing loss
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Throat drainage
- ☐ Throat tickle
- ☐ Sore throat
- ☐ Swollen glands
- ☐ Lump in throat
- ☐ Enlarged thyroid
- ☐ Numerous cavities
- ☐ Teeth grinding
- ☐ TMJ
- ☐ Gum problems
- ☐ Lip sores
- ☐ Mouth sores
- ☐ Excessive saliva
- ☐ Facial pain
- ☐ Facial numbness
- ☐ Sinus problem
- ☐ Sinus drainage
- ☐ Teeth removed

Respiratory

- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Acute cough
- ☐ Tight chest
- ☐ Asthma
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Phlegm
- ☐ Congestion
- ☐ Rattling sound w/ breath
- ☐ Sleep Apnea
- ☐ Can't sleep lying down

Cardiovascular

- ☐ Hypertension
- ☐ Chest pain
- ☐ Palpitations
- ☐ Blood clots
- ☐ Edema
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Irregular heart rate
- ☐ Rapid heart rate
- ☐ Difficulty staying asleep
- ☐ All-night insomnia
- ☐ Difficulty falling asleep

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid regurgitation
- ☐ Gas/flatulence
- ☐ Hiccups
- ☐ Bloating
- ☐ Bad breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Use laxatives
- ☐ Use antacids
- ☐ Use fiber
- ☐ Use digestive enzymes
- ☐ Intestinal pain
- ☐ Very dark stools
- ☐ Very light stools
- ☐ Mucus in stools
- ☐ Foul smell with stool
- ☐ Hemorrhoids
- ☐ Rectal pain/itching
- ☐ Rectal fissures
- ☐ Bowel movement 1x per day
- ☐ Bowel movement less than 1x per day
- ☐ Bowel movement greater than 1x day

Genito-urinary

- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Incomplete urination
- ☐ Blood in urine
- ☐ Dribbling urine
- ☐ Bed wetting
- ☐ Frequent urinary infection
- ☐ Edema
- ☐ Increased libido (men)
- ☐ Decreased libido (men)
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emissions
- ☐ Sexually transmitted disease
- ☐ Kidney stones
- ☐ Urinate _____times per day
- ☐ Wake to urinate ______ times per night
- ☐ Urine odor
- ☐ Dark color urine
- ☐ No color urine

Musculo-skeletal

- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Muscle spasms
- ☐ Joint pain
- ☐ Joint instability
- ☐ Chronic pain
- ☐ Acute pain
- ☐ Muscular atrophy
- ☐ Limited range of motion
- ☐ Arthritis
- ☐ Weather related pain
- ☐ General aches
- ☐ Head pain
- ☐ Shoulder/neck pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Lower back pain
- ☐ Hips pain
- ☐ Upper leg pain
- ☐ Ankle/foot pain
- ☐ Arm pain
- ☐ Wrist/hand pain
- ☐ Other _________

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Neuro-physiological

- ☐ Depression
- ☐ Irritable
- ☐ Easily stressed
- ☐ Easily frustrated
- ☐ Easily worried
- ☐ Anxious
- ☐ Unresolved grief
- ☐ Frightens easily
- ☐ Angers easily
- ☐ Numbness
- ☐ Abuse survivor
- ☐ Receiving counseling
- ☐ Received counseling
- ☐ Poor memory

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Fungal infection
- ☐ Psoriasis
- ☐ Acne
- ☐ Itching
- ☐ Dandruff
- ☐ Premature graying
- ☐ Hair loss
- ☐ Hair changes
- ☐ Hair breaking
- ☐ Thin slow growing nails
- ☐ Dry skin
- ☐ Oily skin
- ☐ Skin discoloration

Vitality and Immunity

- ☐ Frequent colds
- ☐ Frequent flu
- ☐ Tender/achy all over
- ☐ Difficulty concentrating
- ☐ Chronic mental cloudiness
- ☐ Less ability to adapt
- ☐ Slow wound healing
- ☐ Very low energy
- ☐ Lethargic
- ☐ Tired all the time

Gynecology

- ☐ Currently pregnant
- ☐ Possibly pregnant
- ☐ Pregnancies # ______
- ☐ Miscarriages # ______
- ☐ Abortions # _________
- ☐ Pre-mature births # ___
- ☐ Use birth control pills
- ☐ Use other means of birth control
- ☐ Use no birth control
- ☐ Use HRT
- ☐ Menopausal
- ☐ Peri-menopausal
- ☐ Decreased libido
- ☐ Increased libido
- ☐ PMS
- ☐ Pain before flow
- ☐ Pain during flow
- ☐ Bone density changes
- ☐ Fibrocystic breast
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Mastectomy
- ☐ Lumpectomy
- ☐ Reg. self-breast exams
- ☐ Hysterectomy

- ☐ Excess vaginal-discharge/leucorrhea
- ☐ Vaginal odor
- ☐ Vaginal sores
- ☐ Vaginal dryness
- ☐ Vaginal itching
- ☐ Vaginal pain
- ☐ Spotting between cycles
- ☐ Blood clots
- ☐ Heavy bleeding
- ☐ Absent cycle
- ☐ Uterine fibroids
- ☐ Ovarian cysts
- ☐ Endometriosis

Age at Menarche (first period)? _____________

Age at Menopause? ___________________

Date of Last PAP? _______________________

Date of last Mammogram? ______________

Current Menses:

Length of Cycle _________ # of days per month

Duration of Flow? _________# days of bleeding

For practitioner's use only:

Tongue Body: _______________

Tongue Coating: _____________

Pulse Rhythm:____________________

Pulse Depth: _____________________

Pulse Rate: ______________________

Blood Pressure: ______/______

Overall observation: ____

____

____

____

____

____

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Epileptic
- ☐ Pregnant
- ☐ Implanted pain device
- ☐ Diabetic Type I/Type II