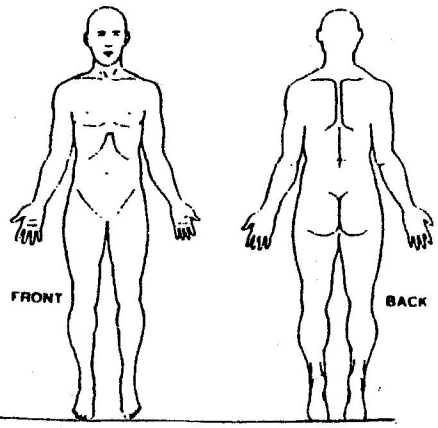
REAL HEALTH
4546 El Camino Real Ste B6
Los Altos, CA 94022
650-949-3637

COMPREHENSIVE ACUPUNCTURE EXAMINATION

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization

Name _____ Date _____ Birthdate: _____
Address _____ Phone (H)_____ How did you hear about our office?
_____ (W) _____
Major Complaints_____ E-mail _____
_____

Please mark your areas of pain



Other Complaints_____
_____
Date of Onset (when you first noticed problem)_____
Symptoms/Pain is Minimal ___ Slight ___ Moderate ___ Severe ___
Have you had this problem in the past? Yes ___ No ___ When? _____
What makes it better? _____
What makes it worse? _____
Is your condition Getting worse ___ Getting Better ___ Comes and Goes _____
Medications/Drugs/Herbs you are taking _____
_____
List Surgeries/Operations you have had and dates _____
_____
Scars (List ALL scars from accidents or surgeries)_____
_____ Primary Care Physician _____

Medical History: (Do you have or have you had) Allergies ___ Arthritis ___ Anemia ___ Heart Trouble ___ Cancer ___
Diabetes ___ Epilepsy ___ Stroke ___ Kidney or Bladder Trouble ___ Gallstones ___ Ulcers ___ High Blood Pressure ___
Chronic Fatigue ___ Hepatitis ___ Jaundice ___ Sudden weight loss ___ Sudden weight gain ___
Other:_____

Family History: (Has any member of your family had any of the above?) Yes ___ No ___ If yes, which member and what did they have?_____

Energy Level High (Time of day) _____ Low (Time of day) _____
Stress: None ___ Moderate ___ Severe ___ What causes it? _____
Sweating Night Sweating ___ Rarely sweat ___ Excess sweating ___
Circulation: Feelings of Hot ___ Cold ___ What area?_____
Bleed easily ___ Cold Limbs ___ Other: _____
Skin: Dry ___Itchy ___ Moist/clammy ___ Burning ___ Changing moles or lumps (cysts/tumors)___ Boils ___ Frequent rashes ___
Acne ___ Hair Loss/thinning ___ Dry scalp ___ Skin puffy/wrinkled ___ Bruises easily ___ Hives ___ Other _____
Sleep: Restful ___ Trouble falling asleep ___ Trouble staying asleep ___ Excess Dreaming ___
Other: _____ How many hours do you sleep a night? _____
Head: Headaches (what area?) _____ Dizziness ___ Memory Loss ___ Loss of balance ___
Other: _____
Eyes: Eye pain ___ Dry eyes ___ Blurred vision ___ Spots or sparkles in vision ___ Darkness under eyes ___ Other: _____
Ears: Poor Hearing ___ Earaches ___ Ear discharge/infections ___ Ringing/buzzing in ears ___Other :_____
Nose: Sinus trouble ___ Frequent nose bleeds ___ Frequent Colds ___ Other: _____
Throat: Sore Throat ___ Hoarseness ___ Difficulty swallowing ___ Jaw problems ___ Gum problems ___ Swollen tongue ___
Other: _____
Chest: Hard to breathe ___ Wheezing ___ Shortness of breath ___Mucous rattles when breathing ___ Trouble at night ___
Pain/pressure in chest ___ Palpitations ___ Persistent cough ___ Coughing blood ___ Coughing phlegm ___
Sputum color _____ Consistency _____
Other: _____
Blood Pressure: High ___ Low ___ Don't know ___
Bowels: Diarrhea ___ Constipation ___ Bloody stools ___ Black stools ___ Mucous in stools ___ Hemorrhoids ___
___ Lower bowel gas ___ Stools have foul odor ___ Colon problems ___ Number of Bowel Movements a day _____
Other: _____
Urine: Color _____ Amount: _____ Frequent urination ___ Daytime ___ At night
Musculoskeletal: Pain in Neck ___ Shoulder ___ Between shoulders ___ Arms/hands ___ Fingers ___ Hip ___ Knee ___
Big toe ___ Upper Back ___ Mid Back ___ Lower Back ___ Bones sore/painful ___ Loss of grip ___ Swollen knees/elbows ___
Leg cramps at night ___ Weakness in legs ___ Weak ankles ___ Stiff all over ___ Tingling in feet ___ Muscle spasms/cramps ___
Loss of feeling in hands/feet ___ Painful joints ___ Bursitis ___
Other: _____

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Neurological: Nervousness ___ Depressed ___ Easily angered ___ Easily irritated ___ Frequent crying ___ Worry/anxiety ___
Mood swings ___ Memory/confusion ___ Poor concentration ___ Suicidal ___ Tremors ___ Numbness/tingling limbs ___
Poor coordination ___ Muscle weakness ___ Feel weak and shaky ___ Seizures ___ Nerve pain (neuralgia) ___ Shingles ___
Males: Low sexual drive ___ Lack of sexual drive ___ Impotence ___ Ejaculation causes pain ___ Discharges ___
Pain or burning while urinating ___ Premature ejaculation ___ Prostate trouble Other: _____
Females: Pregnant? Yes ___ No ___ Last monthly period _____ Last PAP test _____
Form of birth control: ___ None ___ Pill Other: _____
Age started menstrual cycle: _____ Age stopped: _____ Menstrual pain ___ Low backache ___
Irregular ___ Clotting ___ Heavy bleeding ___ Light/scanty bleeding ___ Color _____ Number of days bleeding ___
Water retention ___ Mood changes ___ Miss periods ___ Painful breasts ___ Hot flashes ___ Food cravings Other: _____
Discharges: ___ Yellow ___ Thick ___ White ___ Odor ___ Itching ___ Liquid ___Other: _____
No. of pregnancies _____ No. of deliveries _____ No. of miscarriages _____ No. of abortions _____
No. of Cesareans _____ Operations: ___ Cervix ___ Uterus ___ Ovaries ___ Other: _____
Appetite: Excessive appetite ___ Poor appetite ___ Appetite keeps changing ___ Feel tired or weak if meal is missed ___
Excessive thirst ___ Never thirsty ___ Other: _____
Digestion: : Stomach gas ___ Lower Bowel gas ___ Heartburn ___ Burning/belching ___ Stomach pain ___
Stomach cramps ___ Nausea ___ Vomiting ___ Bad breath ___ Sores in mouth ___ Weight gain ___ Weight loss ___ Bitter/sour taste in mouth ___ Abdominal bloating ___ How long after eating? _____
Food allergies? ___ If yes, to what? _____
NUTRITION: List some of your favorite foods _____
_____
Do you: Skip breakfast ___ Eat a snack ___ Eat a hearty breakfast ___
How many meals a day do you eat? ___ When is your biggest meal? _____
Do you eat when you are worried or rushed? Yes ___ No ___ How often? _____
Do you plan your meals around the "Four basic food groups"? Yes ___ No ___
How many glasses of water do you drink in a day? ___ Filtered ___ Bottled ___
Do you use: Alcohol Yes ___ No ___ Amount per week _____ Type _____
Tobacco Yes ___ No ___Packs per day _____ How many years _____

Do you:

Eat raw fruits or vegetables at least twice a day:	Yes ___	No ___
Eat green or yellow vegetables at least twice a day:	Yes ___	No ___
Eat meat or dairy products 2 or more times a day"?	Yes ___	No ___
Eat when you are not hungry?	Yes ___	No ___
Eat frequently between meals?	Yes ___	No ___
Eat until you feel full?	Yes ___	No ___
Chew your food thoroughly before swallowing it?	Yes ___	No ___
Occasionally go on a "crash" diet?	Yes ___	No ___
Drink juice, milk, or other drinks instead water when thirsty?	Yes ___	No ___
Always buy the cheapest foods?	Yes ___	No ___
Always add salt to the table?	Yes ___	No ___

Financial Policy:

Payment is requested at the time of your office visit unless prior arrangements have been made.

I agree to pay for all services rendered including missed appointments without adequate notice and any balance due amounts that may be as a result of billing insurers. I hereby assign benefits and authorize release of information to any third party payors.

I understand that if I have not been seen for 12 months, the initial visit fees will apply.

I hereby give my informed consent for treatment.

Patients signature: _____ **Date:** _____