Acupuncture Consultation Form

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Name:_____

Age:____ **Sex:** Male Female

Below, describe all of your complaints on the left side of the page, then list how long you have had them and how you are treating them on the right side. Be sure to mention any drugs, vitamin supplements, or medicinal substances you are taking.

Complaints	How long?	Treatment

Brief heath history (list major diseases, surgeries, etc.)**:**

How many times per year do you get the cold or the flu?

Diet (summarize how you eat)**:**

Family Medical History:

Emotions:

	Yes	No
Depression		
Panic attacks		
Sensitive		
Worried		
Anxiety		
Overly excited		
Angry		

Describe:

Energy:

	Yes	No
Low		
Up & down		
Exhausted		
Hyperactive		
Nervous energy		
Abundant		

Describe:

Sleep pattern:

	Yes	No
Falling asleep sometimes difficult		
Falling asleep always difficult		
Sleepy in daytime		
Take naps		
Wake up during the night		
Wake up at night & cannot go back to sleep again		
Wake up too early		
Deep sleeper		
Light sleeper		
Many dreams		
Bad dreams		
Talking in sleep		
Grinding teeth		
Apnea		

Describe:

Menstrual cycle:

Age of onset:____ Date of last period:____ Days per cycle: ____
Color: pale red ____ dark red ____ bright red ____ purplish ____

Menstrual Pain:

	Yes	No
Before flow		
During flow		
After flow		
In abdomen		

Describe:

In back		
In breasts		

Describe:

Emotions around period:

	Yes	No
Depression		
Crying		
Irritability		
Anger		

Temperature:

	Yes	No
Feel cold easily		
Cold hands		
Cold feet		
Alternating hot & cold		
Feel hot easily		
Hot flashes		
Sensitive to weather changes		

Describe:

Sweating:

	Yes	No
Too easily		
Too much		
Difficult		
Too little		
Night sweats		

Describe:

Sensitivities & Allergies:

	Yes	No
Cold		
Hot		
Dampness		
Light		
Noise		
Airborne particles		
Food		
Drugs		

Describe:

Appetite & Digestion:

	Yes	No
Poor appetite		
Nausea		
Anorexia		
Hungry, but no desire to eat		
Bloating		
Gas		

Describe:

Bowel movement: Number of times per day____

	Yes	No
Constipation		
Diarrhea		
Loose stools		
Watery stools		
Incomplete		
Hard & dry		
Strong smell		
With mucous		
With blood		

Describe:

Body Weight: Weight ____

	Yes	No
Average		
Overweight		
Underweight		

Describe:

If overweight:
How many pounds would you like to lose? ____
How many years ago did you first start to gain weight? ____
Are you following a weight control program at this time? ____

Drinking:

	Yes	No
Thirsty		
Dry mouth		
Dry mouth but no desire to drink		
Drink a lot		

Describe:

Urination:

	Yes	No
Frequent		
Urgent		
Burning		
Painful		
Cloudy		
Dark color		
Foul smell		
Bloody		
Difficult		
Retention		

Describe: