Jung Yun Acupuncture

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Note: information provided on this form is confidential. Today's Date ___ /___/___

Name: _____Age:_____ Sex: Male □ Female □

Address_____Occupation _____

City_____State_____Zip_____Date of birth ___/___/___

Telephone: Day_____Ext._____Evening:_____e-mail _____

How did you hear about us? _____

Under a physicians care?_____Name & phone of physician: _____

What would you like treated by Acupuncture?_____

How long have you had this condition?_____Was onset sudden □ gradual □

Symptoms are worse by_____Symptoms better by _____

What medical diagnosis have you received? _____

What other treatments have you received for this and/or other conditions? _____

_____

How has this condition changed your life?_____

_____

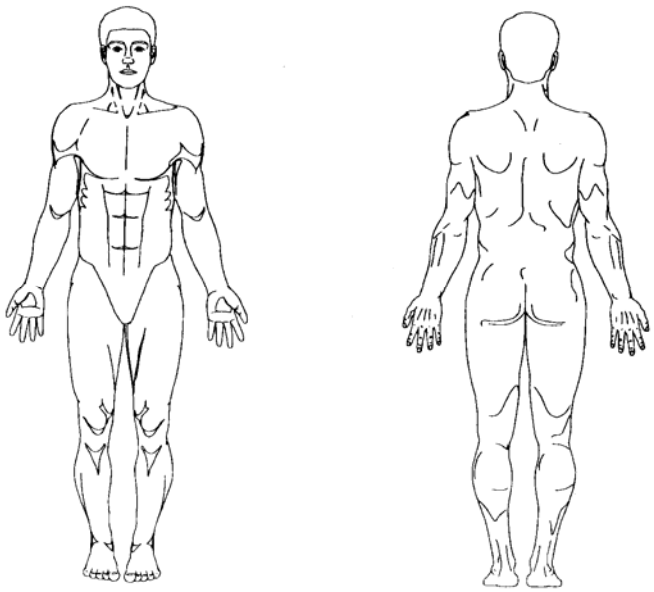
Are you taking any medication? Please note all medication, herbs, vitamins and minerals you take even if you take them only occasionally._____

_____

Are you <u>currently</u> pregnant? Yes □ No □

Are you <u>presently</u> trying to get pregnant? Yes □ No □

On the following drawing shade the areas which you feel should be addressed.



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Medical History

Birth: Anything significant about your birth? _____

_____

Vaccination history: Any reaction that you remember? Any unusual vaccination?_____

_____

Childhood illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age:_____

_____

____age:_____

_____

____age:_____

_____

Adolescence illnesses: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age:_____

_____

____age:_____

_____

____age:_____

_____

Adulthood: Any surgery or accidents? Please list in chronological order and indicate length or illness or injury.

____age:_____

_____

____age:_____

_____

____age:_____

_____

Family history: please note all major illnesses in your close family such as diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.

_____

_____

_____

_____

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Underline current conditions. Put a check mark in the box for former conditions. Add any additional information regarding duration, frequency, intensity and pain regarding current symptoms.

Have you had any of these?

□ AIDS/HIV	□ Cancer	□ Lyme Disease	□ Seizures
□ Alcoholism	□ Diabetes	□ Multiple Sclerosis	□ Tuberculosis
□ Allergies	□ Emphysema	□ Pacemaker	□ Polio
□ Asthma	□ Heart Disease	□ Lymph nodes removed	□ Rheumatic Fever
□ Hepatitis A/B/C	□ Scarlet Fever	□ Headache	□ Birth Trauma
□ Herpes	□ Other _____		(your own birth)

Diet and Food:

How is your appetite? Good □ Poor □ No appetite □Hungry all the time □

Any food cravings?: _____

List any food intolerances: _____

Describe meals for a typical day: Breakfast_____

Lunch: _____Dinner:_____

How often do you have: meat _____day/wk Coffee or Tea (caffeinated)_____day/wk

Sugar/Sweets _____day/wk Dairy (milk, cheese, yogurt) _____day/wk

Are you always thirsty? Yes □ No □ Do you prefer Hot □ or Cold □ drinks?

How many glasses/cups do you have daily: Water _____ soda _____ Coffee/Tea _____

Alcohol _____day/wk

Do you have unusual sweating? When? _____other _____

Rate your taste preferences 1 to 5 (1=like most to 5=dislike):

Salty_____ Sour _____ Bitter _____ Sweet _____ Spicy _____

Exercise and Energy:

How is your energy?_____

What time of day is your energy: Highest? _____ Lowest _____

Do you fatigue easily? _____

Does movement make you feel : less tired □ or more tired □

What kind of exercise do you do? _____

How often do you exercise? _____

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Emotions and Sleep:

How do you feel emotionally?_____

Do you have (check all that apply): Panic attacks □ Depression □ Anxiety □ Bad Temper □

Nervousness □ Fear attacks □ Poor memory □ Difficult concentration □

Other: _____ Married or Stable relationship □ Single □

How do you feel about your relationship?_____

How do you hold stress?_____

How do you relax? _____

How do you feel about your work? _____

Do you use any prescription or non-prescription substances? Anti-depressants □ Sleeping pills □

Other: _____

How long do you normally sleep? _____ hours per night

I have difficulty with (check all that apply): Falling asleep □ Staying asleep □ Disturbed Sleep □

Waking up at about _____am/pm and not being able to fall asleep again because

_____

Skin and Hair:

I have (check all that apply): Dry skin □ Skin rashes □ Itching □ Acne □ Eczema □ Hives □

Hair loss □ Premature graying □ Other: _____

Respiratory, Eyes, Ears, Nose, Throat & Head:

Do you smoke? Yes □ No □ _____ per day, for _____years

I have (check all that apply):Frequent colds □ Chronic runny nose □ Chronic cough □

Coughing blood □ Pain inhaling □ Shortness of breath on exertion/at rest □ Asthma □ Nose bleeds □

Pain/red eyes □ Poor vision □ See spots □ Dizziness □ Cold sores □ Bleeding gums □ Dry mouth □

Ear pain □ Ringing in ears □ Clogged/popping ears □

Frequent sore throat □ Cough up mucous □ How much? ____ Color of phlegm? _____

Frequent headaches/migraines □

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Cardiovascular:

Blood pressure: ____/____ Have you been diagnosed with heart trouble? Yes□ No □

I have (check all that apply): Chest pain □ Palpitations □ Irregular heart beat □ Phlebitis □

Varicose veins □ Cold hands and feet □ Poor circulation □

Gastrointestinal:

I have (check all that apply): Belching □ Nausea □ Vomiting □ Vomiting of blood □ Ulcers □

Acid regurgitation □ Heartburn □ Hernia □ Indigestion □ Severe stomach pains □

Other : _____ Bowel movements: How often? _____ day/week

Painful bowel movement? Yes □ No □

I have (check all that apply): Irregular □ Constipation □ Diarrhea □ Gas □ Burning □ Hemorrhoids □

Use laxatives □ Undigested food in stool □ Loose stool □ Hard stool □ Blood in stool □ Itchiness □

Other: _____

Muscles, Joints and Bones:

Do you have pain or tightness? Where? _____

The pain is (check all that apply): Sharp □ Aching □ Numb □ Deep pain □ Burning □ Dull □

Superficial pain □ Tingling □ Pain worse or better with heat □ Pain worse or better with cold □

Pain worse in am or pm □

I have (check all that apply): Swollen joints □ Arthritis/joint pain □ Tendinitis □ Rheumatism □

Bone pain □ Muscle cramping □ Muscle pain □ Repetitive strain □

Other:_____

Urinary & Genital:

Urination: How often? ____ times per day. Color. Pale yellow □ Dark yellow/orange □

I have or have had (check all that apply): Trouble starting stream □ Frequent urination □

Incontinence □ Trouble holding urine □ Pain □ Burning □ Dribbling when sneezing □

Urinary tract infections □ Blood in urine □ Kidney stones □ Other: _____

How is your sexual energy? _____

What kind of birth control do you use? _____

Do you have (check all that apply): Infertility □ Pain during sexual relations: □

Other: _____

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Women:

At what age did you start menstruation?_____ Number of days between cycles: _____

Number of days of flow:_____ Color:_____ I have or have had (check all that apply):

Irregular menstruation □ Heavy flow □ Light flow □ No flow □ Clots □

Vaginal itching/burning □ Spotting between periods □ Discomfort/pain before period □

Discomfort/pain during period □ Other:_____

Any vaginal discharge? Yes □ No □ Amount _____ Color _____ Frequency _____

Lumps in the breast □ Congested breast □ Breast tenderness □

Blood or mucous discharge from breasts? Yes □ No □ Amount_____ Frequency _____

PMS symptoms: _____

What makes these symptoms better? _____

Are you using birth control? What type?_____

Number of pregnancies?_____ Number of deliveries? _____ Abortion(s)/Miscarriage(s)? _____

Pregnancy complications? Please describe: _____

Menopausal □ Symptoms: _____

Reduced sexual energy? Yes □ No □

Men:

I have (check all that apply): Prostatitis □ Impotence □ Penis blood/mucous discharge □

Pain associated with genitals □ Premature ejaculation □ Reduced sexual energies □

Seminal emission □

Other: _____