BEYOND ZEN

ACUPUNCTURE | PILATES | YOGA | MASSAGE

*All information is important to your intake and valuable to your personal treatment plan.

Please answer as thoroughly as possible.

Acupuncture - Patient Information:

Name: _____Date: _____/_____/_____

(First Middle Last)

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Work Phone: _____ Cell: _____

Date of Birth: _____ Age: _____ Email: _____

Legal Guardian name (if under 18 years old) _____

Emergency Contact info: _____

(Name Relationship Phone)

Gender: _____ Height: _____ Weight: _____ Relationship status: _____

Employer: _____ Occupation: _____

Have you had Acupuncture before? If so where?

_____

How did you hear about our office? _____

Major Complaints

What are the major health concerns for which you are seeking treatment and approximate date they started?

1._____ (Date) _____

2._____ (Date) _____

3._____ (Date) _____

Medical History

Do you have any known Allergies? _____

Please list any surgeries and approximate date of occurrence.

_____

_____

Please list any other traumas/ accidents/ injuries.

_____

Have you experienced any emotional traumas (abuse, loss of a loved one, divorce etc.)? Please explain.

_____

Please check any conditions that you have experienced in the past:

_____ Asthma
_____ Bleeding Disorder
_____ Cancer
_____ Chicken Pox
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Glaucoma
_____Hepatitis
_____Heart Disease
_____ High Blood Pressure
_____ HIV
_____ Jaundice
_____ Kidney Disease
_____ HIV
_____Liver Disease
_____ Lung Condition
_____ Measles
_____ Meningitis
_____ Migraines
_____ Mononucleosis
_____ Multiple Sclerosis
_____ Mumps
_____Nervous Disorder
_____ Paralysis
_____ Pneumonia
_____Polio
_____Rheumatic Fever
_____ STD
_____ Stroke
_____ Thyroid Condition
_____ Tuberculosis
_____ Vein Condition

Please check all symptoms you currently experience:

General Temperature:

_____Hot body sensation _____ Cold Body Sensation _____ Heat in hands, feet _____ Hot flash
_____ Cold hands/feet _____ Night sweats _____ Perspires easily _____ Thirst

Energy Levels:

_____ Low energy _____Difficult keep eyes open (daytime) _____ Shortness of breath
_____ General weakness _____ Worse with exertion

Blood Function:

_____ Dizziness _____ Brittle nails _____ Numbness _____ Tingling sensation

Heart function:

_____ Palpitations _____ Anxiety _____Restlessness
_____ Sores on tip of tongue _____ Chest pain _____ Mental Confusion

Spleen function:

_____Abdominal gas _____ Low appetite _____ Bruise easily
_____ Abdominal bloat _____ Crave sweets _____ Overthink / Worry
_____ Loose stools _____ Gurgling sounds _____ Hemorrhoids
_____ Weight gain _____ Weight loss _____ Fatigue after eating
_____ Prolapsed organs _____Undigested food particles in stool

Stomach function:

_____ Heartburn
_____ Bad breath
_____ Hiccups
_____ Swollen, painful, bleeding gums
_____ Acid reflux
_____ Canker/ mouth sores
_____ Vomiting
_____ Stomach pain
_____ Large appetite
_____ Belching
_____ Ulcer
_____Burning feeling after eating

Intestine Function:

_____ Constipation
_____ Mucous in stool
_____Incomplete stools
_____ Diarrhea
_____Blood in stool

Dampness in the body:

_____ General heaviness
_____ Swollen joints
_____ Mental sluggishness
_____ Swollen hands
_____ Mental heaviness
_____ Chest Congestion
_____ Swollen feet
_____ Mental fogginess

Lung function:

_____ Frequent colds
_____ Sinus Congestion
_____ Dry nose
_____ Sneeze
_____ Skin rashes
_____ Cough
_____ Difficult breathing
_____ Dry mouth
_____ Sore throat
_____ Tightness in chest
_____ Chills/ fever
_____ Dry Skin
_____ Dry throat
_____ Sadness/ Grief

Kidney/ Bladder function:

_____ Low Back pain
_____Breaks bones easily
_____Low pitched ringing in ears
_____ Wakes during night to urinate
_____ Frequent urine
_____ Scanty urine
_____ Cloudy urine
_____ Pale Urine
_____ Loss of hearing
_____ Weak knees
_____ Poor memory
_____ Lack of bladder control
_____ Bladder infections
_____ Urgent urine
_____ Difficult urine
_____ Painful urine
_____ Low sex drive
_____ Excessive hair loss
_____ Sore knees
_____ Fear
_____Kidney Stones
_____ Easily startled
_____ Blood in urine
_____ Profuse urine
_____Dark yellow urine
_____ Craves salty foods
_____Discharge

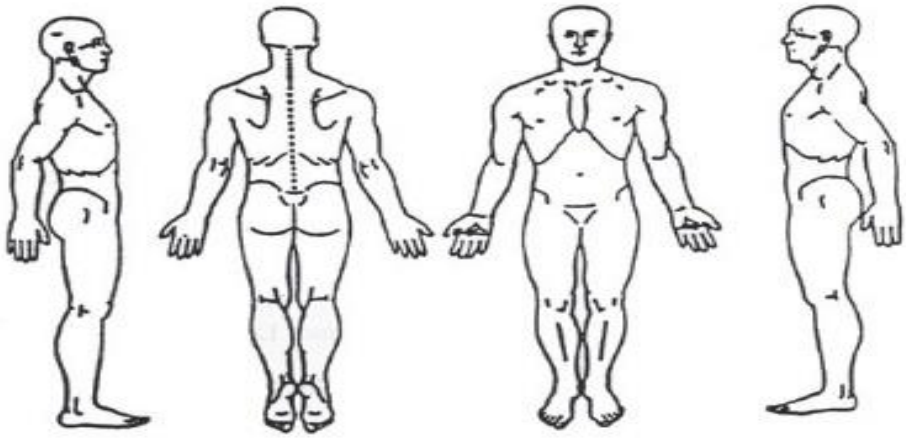
Liver/ Gallbladder function:

_____ Frustration
_____ Depression
_____ Muscle cramps
_____ Headache (top of head)
_____ Sensation of lump in throat
_____ Gallstones
_____ Limited Range of Motion
_____ Angers easily
_____ Muscle spasms
_____ Seizure
_____ Tension headache
_____ High pitched ring in ears
_____ Nausea
_____ Convulsions/Tremors
_____ Irritable
_____ Muscle twitch
_____ Bitter taste
_____ Neck tension
_____ shoulder tension
_____ Increased stress
_____ Pale stools

Eye function:

_____ Dry
_____ Red
_____ Hot
_____ Itchy
_____ Watery
_____ Gritty
_____ Blurry
_____ Vision problems
_____ Spots/ floaters

Please differentiate and indicate any areas of pain or scar locations:



Nature of pain:

_____ Dull _____ Achy
_____ Sharp _____ Burning
_____ Cramping _____ Fixed
_____Moving _____Numbness
_____ Pins/Needles _____ Other

Some relief through:

_____ Pressure _____ Heat
_____ Cold _____ Exercise
_____ Other

Symptoms worsen with:

_____ Pressure _____ Heat
_____ Cold Other: _____

Sleep Habits

How many hours a night do you sleep? _____

Do you experience any of the following?

_____ Difficulty falling asleep
_____ Waking 1 or more times during the night
_____ Insomnia
_____ Feeling not rested or groggy upon waking
_____ Awaking too early

Dietary/ Lifestyle Habits

Please describe what you typically eat for breakfast, lunch, dinner.

_____

_____

_____

Do you drink coffee? _____ Amount per week? _____

Do you drink soda/pop? _____Amount per week? _____

How much water do you drink in a day? _____

Do you drink alcohol? _____ Amount per week? _____

Do you smoke cigarettes? _____ Amount per week? _____

Recreational drug use? _____ Amount per week? _____

Do you Exercise? _____ Amount per week? _____

Do you have any hobbies? _____

For Men Only: Do you experience any of the following?

_____ Impotence
_____ Pre-mature ejaculation
_____Swollen testes
_____Cold or Numbness in groin area
_____ Nocturnal emissions
_____ Testicular pain

Date of last prostate exam? _____PSA number? _____

For Women Only:

Are you pregnant or do you think you may currently be pregnant? _____
Age of first menstruation _____

Do you have regular cycles? _____ How many days is your entire cycle? _____

How many days does your period last? _____

Do you experience vaginal discharge? _____

Number of pregnancies? _____ Births? _____ Abortions? _____ Miscarriages? _____

Age of Menopause? (If applicable) _____

Have you experienced bleeding between periods? _____

Do you experience any of these PMS symptoms?

_____ Breast Swelling
_____ Nausea
_____ Anxiety
_____ Food cravings
_____ Dull pain
_____ Breast tenderness
_____ Vomiting
_____ Headaches
_____ Bloating
_____Sharp pains
_____ Depression
_____ Irritability
_____ Migraines
_____ Change in bowels

Have you been diagnosed with any of the following?

Fibroids _____ PCOS _____ PID _____ Endometriosis_____ Cysts _____

Menses chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (pale, bright red, brown, rusty, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Clotting (small, large, red, purple, black, other)							
Pain/ Cramping (location, dull, sharp)							
Other							

Please list any Medications/Supplements/Vitamins you currently take:

Date started	Medication/ Vitamin/ Supplement	Reason for taking	Dosage	Amount	Frequency