ACUPUNCTURE HEALTH SERVICES
Rita F. Stanford, C.M.T., Dipl. Ac., L. Ac., Dipl. C.H., D.A.O.M.
Doctor of Acupuncture and Oriental Medicine
2760 29th St, Suite 1D
Boulder, Colorado 80301

Name:	Phone (Hm):	Phone (Wk):
Street:	Age: Height:	Weight:
City:	Birth Date:	
State: Zip:	Occupation:	
Primary Medical Doctor:	Referred By:	
Martial Status:	Social Security No:	
For Emergencies, Contact Info:	Name:	Emergency # 1:
Email:	Name:	Emergency # 2:

Acupuncture has been explained to me as a treatment of inserting needles through the skin of specific points on the surface of the body to obtain the alleviation or cure of illness. I understand that there may be some complications and possible side effects of Acupuncture or Herbal medicine, such as Hematoma, pain and discomfort, fainting, allergy or aggravation of symptoms, nausea and/or heart palpitations.

Signed:_____ Date:_____

****When filling out this form, please be specific, and if necessary, make notes in the margins.****

Reasons for Your Visit Today

Please list your complaints, chief complaint first, and how it began, and **HOW LONG you have had the symptoms?**

Medical History

Allergies – please list any allergies (food, inhalants, contactants, etc.)

Major Illnesses – List any major illnesses that you have had and the date you had the illness:

Illness:	Date:	Illness:	Date:
Illness:	Date:	Illness:	Date:

Trauma (auto accidents, falls, etc.) – List any trauma that you have experienced and the date it happened:

Trauma:	Date:	Trauma:	Date:
Trauma:	Date:	Trauma:	Date:

Surgeries – List any surgeries you have had and the date for each surgery:

Surgery:	Date:	Surgery:	Date:
Surgery:	Date:	Surgery:	Date:

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Patient Name:_____

Medications and Vitamins

List any medications, vitamins, or supplements that you are currently taking:

Life Style

Number of meals that you eat per day:_____ Times that you usually eat:_____

How often do you consume the following? **(Times per Week)**

Drugs:		Soft Drinks:		Alcohol:	
Caffeinated Coffee:		Uncaffeinated Coffee:		Uncaffeinated Tea:	
Caffeinated Tea:					

What exercises do you do?	How Often?	What exercise do you do?	How Often?

Diet

How often do you consume each of the following?

Beef:	Pork:	Poultry:	Fish:
Eggs:	Cheese:	Butter:	Beans:
Tofu:	Added Salt:	Sugar:	Vinegar:
Green Vegetables:	Other Vegetables:	Grains:	Sweets:
Ice Cream:	Yogurt:	Milk:	Soy Milk:
Spicy Foods:	Fatty Foods:	Other:	

List any food cravings: _____

Comments: _____

List any foods that you find hard to digest: _____

Family Medical History

Please list those in your family who have experienced any of the following:

Heart Diseases: _____

Diabetes: _____

Allergies: _____

High Blood Pressure: _____

Cancer: _____

Epilepsy: _____

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Patient Name:_____

General Information

Check the answer that best describes the following:

Appetite:	□ Good	□ Poor	□ Excessive	
Sleep:	□ Good	□ Poor	□ Excessive	
Energy:	□ Good	□ Poor	□ Excessive	
Tired all the time:	□ Yes	□ No		
Tired in the morning:	□ Never	□ Sometimes	□ Often	□ Always
Tired after eating:	□ Never	□ Sometimes	□ Often	□ Always
Body Temperature:	□ Normal	□ Warm	□ Fever	□ Hot Flush
	□ Cold (whole body)			
Sweat easily:	□ Yes	□ No		
Night sweats:	□ Never	□ Sometimes	□ Often	□ Always
Thirsty:	□ Never	□ Sometimes	□ Often	□ Always
Overweight:	□ Yes	□ No		
Underweight:	□ Yes	□ No		
Peculiar taste in mouth:	□ Yes	□ No		
Peculiar smells:	□ Yes	□ No		

Respiratory

Check symptoms that you experience. On line please indicate if the symptom is:

INCONSISTENT (I), CURRENT (C), PAST (P), or OFTEN (O)

□ Shortness of Breath____	□ Chest pain____	□ Difficulty breathing____	□ Tight chest____
□ Productive Cough____	□ Dry cough____	□ Cough up blood____	□ Asthma____
□ Pulmonary Heart Disease_____	□ TB____	□ Emphysema____	□ Bronchitis____
□ Want to stop smoking____	□ Have tried successfully____	□ Sigh a lot____	□ Sputum____
If you cough sputum:	Color_____	Amount_____	

Cardiovascular

Please fill in the following: Blood Pressure:_____ Blood Lipid:_____ Triglycerides:_____ Cholesterol:_____

Check symptoms that you experience. On line please indicate if the symptom is:

INCONSISTENT (I), CURRENT (C), PAST (P), or OFTEN (O)

□ Palpitations____	□ Pericardial Pain/Angina Pectoris____	□ Tachycardia____	□ Irregular Heart Beat____
□ Bradycardia____	□ Cold Hand and Feet____	□ Murmur____	□ Bruise Easily____
□ Varicose Veins____	Where:_____		

Gastrointestinal

Check symptoms that you experience. On line please indicate if the symptom is:

INCONSISTENT (I), CURRENT (C), PAST (P), or OFTEN (O)

□ Indigestion____	□ Nausea____	□ Vomiting____	□ Acid sour regurgitation____
□ Heartburn____	□ Gas____	□ Reflux____	□ Nervous stomach____
□ Hemorrhoids____	□ Black stool____	□ Bloody stools____	□ Abdominal pain____
□ Diverticulitis____	□ Chronic colitis____	□ Hiccup____	
Are you bowel movements: □ Formed or □ Unformed?		How many bowel movements per day?_____	
What color are your bowel movements?_____		Do your bowel movements have a peculiar smell?_____	

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Patient Name:_____

Genito-Urinary

Check all that apply to you. On line please indicate if the symptom is:

INCONSISTENT (I), CURRENT (C), PAST (P), or OFTEN (O)

□ Frequent urination____ □ Urgency to urinate____ □ Pain/burning on urinating____ □ Bet wet____

□ Profuse urine____ □ Feeble urination____ □ Turbid/cloudy urine____ □ Dribbling____

□ Incontinence of urine_____ □ Blood in urine____ □ Strong smell urine____ □ Scanty urine____

How often do you urinate per day?_____ How often do you urinate during the night?_____

Have you had kidney or bladder stones? □ Yes or □ No ----- If yes, when?_____

Check all that apply to you.

□ Impotency □ Premature ejaculation □ Seminal emission □ Vasectomy

□ Reduced sex drive □ Increased sex drive □ Infertility/Sterility □ Tubal ligation

□ Venereal disease □ Herpes genitalia □ AIDS □ Other birth control_____

Musculoskeletal

Check the answer that best describes the following:

Muscle pain:	□ Sharp	□ Dull	□ Stabbing	(location)
Joint pain:	□ Sharp	□ Dull	□ Stabbing	(location)
Muscle weakness or atrophy:		□ Yes	□ No	(location)
Limited range of motion:		□ Yes	□ No	(location)
Broken bones:	□ Never	□ Yes	□ No	(location)
Bone problems:	□ Never	□ Yes	□ No	(location)
Pain/distention in hypochondriac region (below ribcage):		□ Yes	□ No	

Other:_____

Neuropsychological

Check all that apply to you. On line please indicate if the symptom is:

INCONSISTENT (I), CURRENT (C), PAST (P), or OFTEN (O)

□ Areas of numbness: (Where)_____

□ Areas of pain: (Where)_____

□ Area of neuralgia (Where)_____

□ Migraines____ □ Other headaches____ (Location)_____

□ Dizziness____ □ Vertigo____ □ Balance problems____ □ Seizures____ □ Depressed____

□ Moody____ □ Happy____ □ Melancholy____ □ Joy____ □ Poor Memory____ (short / long-term)

□ Hostile____ □ Irritable____ □ Fly off the handle____ □ Pensiveness____ □ Angry____ (expressed / repressed)

□ Impatient____ □ Indecisive____ □ Hard to fall asleep____ □ Weak will____ □ Strong will____

□ Anxiety____ □ Sad____ □ Wake up easily____ □ Wake up every night at (TIME):_____□

Other Emotions, Mood, Temperament, or Characteristics:

_____

_____

_____

_____

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Patient Name:_____

Check all that apply to you. On line please indicate if the symptom is:

INCONSISTENT (I), CURRENT (C), PAST (P), or OFTEN (O)

Hair

□ Dry____ □ Oily____
□ Dandruff____ □ Hair loss____
□ Early Graying____ □ Dyes hair____

Skin

□ Dry____ □ Scale/squamous____ □ Oily____ □ Rashes____
□ Itching____ □ Psoriasis____ □ Eczema____ □ Jaundice____
□ Pimples____ □ Recent moles____ □ Boils____ □ Warts____
□ Hives____ □ Mole changes____ □

Ears

□ Poor hearing____ □ Tinnitus/Ringing(pitch)____
□ Discharge____ □ Pain (dull/stabbing)____
□ Hearing loss____ □ Frequent childhood infections___
□ Itching____ □ Sensitive to noise____

Eyes

□ Dry___ □ Night blindness____ □ Pain____
□ Tear easily____ □ Profuse discharge____ □ Swollen____
□ Wear glasses____ □ Sensitive to light____ □ Strain____
□ Blurry vision____ □ Spots in vision____ □ Twitch____
□ Color blind____ □ Sensitive to wind____ □ Itching____
□ Cataracts____ □ Frequent blinking____ □ Irritated____
□ Glaucoma____

Mouth, Throat, Head

□ Dry mouth____ □ Copious saliva____
□ Grind teeth____ □ Sores in mouth____
□ Throat dry____ □ Teeth problems____
□ Throat sore____ □ Difficult swallowing____
□ TMJ____ □ Jaw clicks____

Nose

□ Swollen or painful glands____ □ Stuffy____ □ Loss of smell____
□Gum problems____ □ Sinusitis____ □ Post nasal drip____
□ Sinus pain____ □ Bleeding____ □ Lump in throat____
□ Thyroid problems____ □ Mucous color____

Gynecology

Please answer these questions, **EVEN IF YOU HAVE HAD A HYSTERECTOMY OR GONE THROUGH MENOPAUSE**.

Menarche (Age menstruation started):_____ Menopause (Age menstruation stopped): _____
Last Menses: _____ Regular Period - # of days of cycle: _____
Flow (days, amount, color, clots): _____

Check any of the following that apply to you:

□ Irregular periods □ Dysmenorrhea □ Edema □ Spotting between periods □ PMS (when)_____
□ Abdominal bloating □ Emotional changes □ Diarrhea □ Other complaints_____

Pregnancy

Number of births_____ Number of Artificial Abortions_____ Number of spontaneous miscarriages____
Number of premature births_____ Number of delayed births_____ Labor complications_____
Pregnant now? □ Yes □ No If pregnant, what is the conception date? _____
_____ _____

Check any that apply:

□ Desire to get pregnant □ Threatened Abortion □ Uterine bleeding □ Restless fetus □ Cramps □ Morning sick
Birth Control Type_____ Other_____
Other Information:_____

PATIENT STOPS HERE

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Date:_____ Patient Name:_____

BP: _____

PULSE RATE: _____

BREATH RATE: _____

TONGUE: _____

PULSE: _____ LEFT: _____ RIGHT: _____

DIAGNOSIS: _____

ANALYSIS: _____

TREATMENT STRATEGY: _____

ACU: _____

HERBS: _____

SUMMARY: