Acupuncture Consultation Form

Date _____

First Name_____ Last Name _____ DOB_____

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 directly opposite on the right side. Be sure to mention any drugs, vitamins Supplements, or other medical substances you are taking.

Complaints *(Brief health history)*	How long have you had it?	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

What medications and/or supplements are you taking and for how long?

_____

Emotions

☐ Normal ☐ Problem ☐ Depression ☐ Sadness ☐ Panic attack ☐ Sensitive ☐ Worries ☐ Overly excited ☐ Angry ☐ Anxiety

Describe: _____

Energy

☐ Normal ☐ Problem ☐ Low ☐ Up and down ☐ Exhausted ☐ Hyperactive ☐ Nervous energy ☐ Abundant

Describe: _____

Sleep Pattern ☐ Normal ☐ Insomnia

Falling Asleep ☐ Sometimes difficult ☐ Always difficult ☐ Sometimes very difficult ☐ Always very difficult ☐ Sleepy in daytime ☐ Take naps

Waking Up ☐ Times per night ☐ Wake up too early ☐ Wake up at night and cannot go back to sleep again

Sleep Quality ☐ Deep ☐ Light ☐ Poor ☐ Many dreams ☐ Bad dreams ☐ Grinding teeth ☐ Talking in sleep ☐ Other

Describe: _____

Diet

Any special diet? _____

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Temperature

☐ Normal ☐ Abnormal ☐ Feel cold easily ☐ Cold hands ☐ Cold feet ☐ Feel hot easily ☐ Alternating hot & cold ☐ Hot flash
☐ Sensitive to weather changes

Describe: _____

Sweating ☐ Normal ☐ Abnormal ☐ Too easily ☐ Too much ☐ Difficult ☐ Too little ☐ Night sweats ☐ Other

Describe: _____

Sensitivity and Allergy ☐ No ☐ Yes

Appetite and Digestion

☐ Normal ☐ Abnormal ☐ Rapid hungering ☐ Poor appetite ☐ Nausea ☐ Anorexia ☐ Hungry, but no desire to eat ☐ Bloating ☐ Gas ☐ Other

Describe: _____

Bowel Movement

☐ Normal ☐ Abnormal ☐ Constipation ☐ Diarrhea ☐ Loose ☐ Watery ☐ Incomplete ☐ Hard and dry ☐ Strong smell
☐ With mucus ☐ With blood ☐ Other Time of day: _____

Describe: _____

Body Weight ☐ Normal ☐ Overweight ☐ Underweight

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? _____

Describe: _____

Drinking

☐ Normal ☐ Abnormal ☐ Thirsty ☐ Dry mouth ☐ Drink a lot ☐ Dry mouth but no desire to drink ☐ Not thirsty, but drink a lot of water anyway

Describe: _____

Urination ☐ Normal ☐ Abnormal ☐ Frequent ☐ Urgent ☐ Burning ☐ Painful ☐ Cloudy ☐ Dark color ☐ Foul smell

☐ Bloody ☐ Difficult Retention ☐ Other Number of time per day: _____ Number of times you get up to urinate at night: _____

Describe: _____

Eye, Ear and Nose ☐ Normal ☐ Abnormal *Describe:* _____

Menstrual Cycle ☐ Regular ☐ Irregular Age of onset: _____ years old Date of last period: _____

How many days between cycles? _____ How many days did it last? _____

Color: ☐ Pale red ☐ Dark red ☐ Bright red ☐ Purplish Were there clots? ☐ Yes ☐ No

Menstrual Pain: ☐ Yes ☐ No ☐ Before flow ☐ During flow ☐ After flow ☐ Abdomen ☐ Back ☐ Breast

Emotion Around Period

☐ Normal ☐ Abnormal ☐ Before flow ☐ After flow ☐ Depression ☐ Irritability ☐ Anger ☐ Sadness ☐ Crying ☐ Other

Describe: _____

Addictions ☐ Tobacco ☐ Alcohol ☐ Others Describe: _____

Any other disorders or abnormalities Describe: _____

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