SUZANNE CLEGG RDN, LAc

COMPREHENSIVE ACUPUNCTURE EXAMINATION

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

Name:_____

Date:_____ Birth Date: _____ Age: _____

Height:_____ Weight:_____

Reason for visit:_____

_____

_____

What other areas (physical, mental, social, or spiritual) if shifted would enhance your well-being?_____

_____

_____

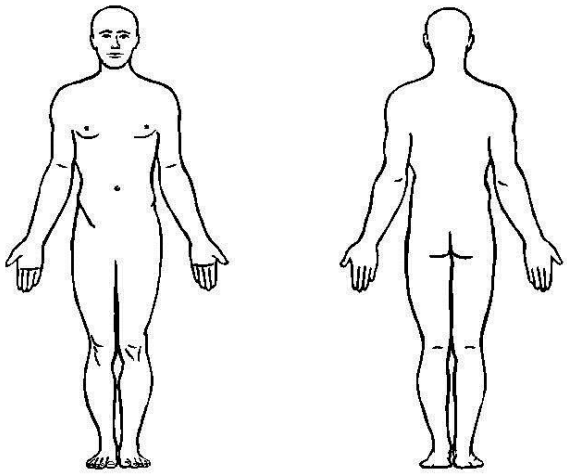
Date of onset (when you first noticed your condition)? ____

How long have you had this condition? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and goes



PLEASE MARK YOUR AREAS OF PAIN

What do you like best about your body? What aspects of your body please you or are extremely reliable or strong?

_____

Prescription medications you are currently taking: _____

Herbs, vitamins, homeopathic remedies you are currently taking: _____

_____

List surgeries/operations you have had and dates: _____

_____

Date of your last physical examination _____ By whom? _____

MEDICAL HISTORY: Do you have or have you ever had:

☐ Arthritis	☐ Chronic fatigue	☐ Stroke	☐ High Blood Pressure
☐ Asthma	☐ Hepatitis	☐ Kidney/bladder trouble	☐ Sudden weight gain
☐ Anemia	☐ Jaundice	☐ Prostate Trouble	☐ Sudden weight loss
☐ Heart trouble	☐ Diabetes	☐ Kidney stones	☐ Gallstones
☐ Cancer	☐ Epilepsy	☐ Ulcer	Other:_____

FAMILY HISTORY

Has any member of your family had any of the above? ☐ Yes ☐ No

If yes, which member and what did they have? _____

_____

ENERGY LEVEL
☐ High (Time(s) of day) _____
☐ Low (Time(s) of day) _____

STRESS
☐ None
☐ Severe
☐ Moderate
What are some causes of stress in your life? _____
_____

SWEATING
☐ Night sweats
☐ Rarely sweat
☐ Excess sweating
☐ Unusually foul odors

SLEEP
☐ Restful and good
☐ Trouble falling asleep
☐ Trouble staying asleep
☐ Excess dreaming
Hours slept each night? _____
Do you work nights and sleep days? ☐ No ☐ Yes
Other:_____

SCARS
List all scars from accidents or surgeries:_____
_____

SKIN
☐ Dry
☐ Itchy
☐ Moist/clammy (ie hands)
☐ Burning
☐ Changing moles or lumps
☐ Cysts/Tumors
☐ Boils
☐ Frequent skin rashes
☐ Acne
☐ Hair loss/thinning
☐ Dry scalp
☐ Skin puffy/wrinkled
☐ Bruise easily
☐ Hives
Other:_____

BLOOD PRESSURE
☐ High
☐ Low
☐ Normal
☐ Do not know

CIRCULATION
Do you experience feelings of:
☐ Hot
☐ Cold
At what areas of your body?
_____
☐ Bleed easily
☐ Cold limbs
Other: _____

HEAD
☐ Headaches
What area(s)? _____
☐ Loss of balance
☐ Dizziness
☐ Memory Loss
Other:_____

NEUROLOGICAL
☐ Nervousness
☐ Depressed
☐ Easily angered
☐ Easily irritated
☐ Worry/anxiety
☐ Frequent crying
☐ Mood swings
☐ Memory confusion
☐ Suicidal
☐ Poor concentration
☐ Tremors
☐ Numbness/tingling in limbs
☐ Seizures
☐ Poor coordination
☐ Muscle weakness
☐ Feel weak and shaky
☐ Neuralgia (Nerve pain)
☐ Shingles
Other:_____

EYES
☐ Eye Pain
☐ Dry eyes
☐ Blurred vision
☐ Darkness under eyes
Other:_____

EARS
☐ Poor hearing
☐ Earaches
☐ Discharge/infections
☐ Ringing/buzzing in ears
Other:_____

NOSE
☐ Frequent nose bleeds
☐ Sinus trouble
☐ Frequent colds
Other:_____

THROAT
☐ Sore throat
☐ Hoarseness
☐ Difficulty swallowing
☐ Jaw problems
☐ Gum problems
☐ Swollen tongue
Other:_____

CHEST
☐ Hard to breathe
☐ Wheezing
☐ Shortness of breath
☐ Mucus rattles when breathing
☐ Trouble breathing
☐ Pain/pressure in chest when breathing at night
☐ Palpitations
☐ Persistent cough
☐ Coughing blood
☐ Coughing phlegm
Sputum color:_____
Consistency:_____
Other:_____

URINE

Color:_____

Amount:_____

- ☐ Frequent Urination
  - ☐ Daytime
  - ☐ At Night
- ☐ Strong smelling urine
- ☐ Hard to urinate
- ☐ Pain or burning on urinating
- ☐ Blood in urine
- ☐ Frequent infections
- ☐ Water retention

Other:_____

MUSCULOSKELETAL

Do you have pain in:

- ☐ Neck ☐ Shoulder
- ☐ Arms/Hands ☐ Fingers
- ☐ Hip ☐ Knee
- ☐ Big toe ☐ Upper back
- ☐ Mid back ☐ Lower back
- ☐ Between shoulders
- ☐ Bones sore/painful
- ☐ Loss of grip
- ☐ Painful joints
- ☐ Swollen knees/elbows
- ☐ Leg cramps at night
- ☐ Weak in legs
- ☐ Weak ankles
- ☐ Stiff all over
- ☐ Tingling in feet
- ☐ Muscle spasms
- ☐ Loss of feeling in hands/feet
- ☐ Painful joints
- ☐ Bursitis
- ☐ Cramps

Other:_____

APPETITE

- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Appetite keeps changing
- ☐ Excessive thirst
- ☐ Never thirsty
- ☐ Feel tired or weak if meal missed

Specific food cravings: ☐ Yes ☐ No

If yes, what? _____

Other:_____

DIGESTION

- ☐ Stomach gas
- ☐ Lower bowel gas
- ☐ Burning/belching
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Stomach cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Bad breath
- ☐ Weight gain
- ☐ Weight Loss
- ☐ Sores in mouth
- ☐ Bitter/sour taste in mouth
- ☐ Abdominal bloating

How long after eating?

_____

Food allergies

- ☐ Yes
- ☐ No

If yes, to what? _____

Other:_____

NUTRITION

List some of your favorite foods:_____

_____

_____

Do you:

- ☐ Skip breakfast
- ☐ Eat a snack
- ☐ Eat a hearty breakfast

How many meals a day do you eat?_____

When is your biggest meal?_____

Do you eat when you are worried or rushed? ☐ Yes ☐ No

How often?_____

Do you plan your meals according to the "Four basic food groups?" ☐ Yes ☐ No

How many glasses of water do you drink a day?_____

- ☐ Tap
- ☐ Filtered
- ☐ Bottled

DO YOU:

Drink alcohol? ☐ Yes ☐ No

Amount per week_____

Type_____

Use tobacco? ☐ Yes ☐ No

Packs per day_____

Years used_____

Eat meat or dairy products 2 or more times a day? ☐ Yes ☐ No

Eat raw fruits or vegetables at least twice a day? ☐ Yes ☐ No

DO YOU:

Eat green or yellow vegetables at least twice a day? ☐ Yes ☐ No

Eat the same foods every day? ☐Yes ☐ No

Eat when you are not hungry? ☐ Yes ☐ No

Eat until you feel full? ☐ Yes ☐ No

Eat frequently between meals? ☐ Yes ☐ No

Chew your food thoroughly before swallowing it? ☐ Yes ☐ No

Occasionally go on a crash diet? ☐ Yes ☐ No

Drink juice, milk or other drinks instead of water when thirsty? ☐ Yes ☐ No

Always buy the cheapest foods? ☐ Yes ☐ No

Always add salt at the table? ☐ Yes ☐ No

MEN

- ☐ Too low sexual drive
- ☐ Too high sexual drive
- ☐ Impotence
- ☐ Discharges
- ☐ Prostate trouble
- ☐ Ejaculation causes pain
- ☐ Premature ejaculation
- ☐ Fertility Issues

Other:_____

WOMEN

Speak to Suzanne about your menstrual cycle.

PATIENT'S SIGNATURE:_____ **DATE:**_____