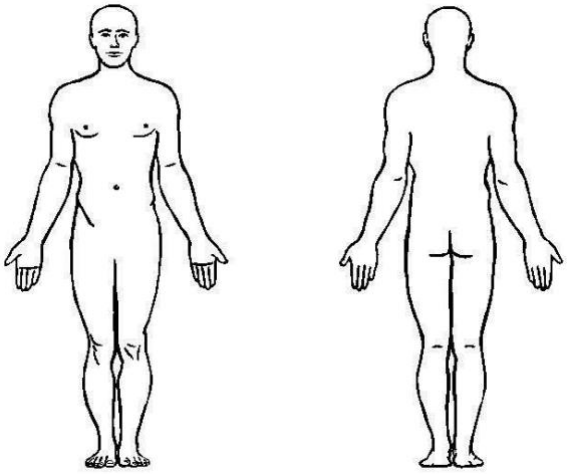
COMPREHENSIVE ACUPUNCTURE EXAMINATION

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.

BALANCE healthcare

Name: _____ Date: _____
Age: _____ Height: _____ Weight: _____
Major Complaints: _____
_____
_____
_____
Other Complaint/s: _____
_____
_____
Date of onset (when you first noticed your condition)?
Pain is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe
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

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 any following problems? If yes, when:

☐ 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? _____
_____

Allergies _____
_____

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 (black and blue spots)

☐ Hives

Other: _____

BLOOD PRESSURE

☐ High

☐ Low

☐ Normal

☐ Do not know

CIRCULATION

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

☐ Palpitations

☐ Persistent cough

☐ Coughing blood

☐ Coughing phlegm

Sputum color: _____

Consistency: _____

Other: _____

URINE

Color: _____

Frequency: _____

☐ Frequent Urination

☐ Daytime ☐ At Night

☐ Strong smelling urine

☐ Hard to urinate

☐ Pain or burning on urinating

☐ Blood in urine

☐ Frequent infections

☐ Water retention

Other: _____

BOWL MOVEMENT

☐ Constipation

☐ Diarrhea

☐ Constipation and diarrhea alternatively

Frequency: _____

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

☐ Swollen knees/elbows

☐ Leg cramps at night

☐ Weak in legs

☐ Weak ankles

☐ Stiff all over

☐ Tingling in feet

☐ Muscle spasms / cramps

☐ Loss of feeling in hands/feet

☐ Painful joints

☐ Bursitis

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? _____

DIGESTION

☐ Stomach gas

☐ Lower bowel gas

☐ Abdominal bloating

☐ Acid reflux / regurgitation

☐ Heartburn

☐ Burning/belching

☐ Stomach pain

☐ Stomach cramps

☐ Nausea

☐ Burping

☐ Vomiting

☐ Bad breath

☐ Weight gain

☐ Unintentional weight loss

☐ Sores in mouth

☐ Bitter/sour taste in mouth

Symptoms occur:

☐ Before eating

☐ Immediately after eating

☐ 1–2 hours after eating

☐ Several hours after eating

☐ At night / when lying down

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 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 _____

Use drug? _____ ☐ Yes ☐ No

Type _____

Eat meat or dairy products every day?

☐ Yes ☐ No

Eat raw fruits or vegetables every day?

☐ Yes ☐ No

DO YOU:

Eat when you are not hungry?

☐ Yes ☐ No

Eat until you feel full? ☐ Yes ☐ No

Eat frequently between meals?

☐ Yes ☐ No

Occasionally go on a crash diet?

☐ Yes ☐ No

Drink juice, milk or other drinks instead of water when thirsty?

☐ 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

☐ Pain or burning while urinating

Other: _____

WOMEN

Pregnant? ☐ Yes ☐ No
Last monthly period
Last PAP test

Form of birth control:
☐ None
☐ Pill
Other:

Age started menstrual cycle:
Age stopped:

☐ Menstrual Pain
☐ Low backache
☐ Irregular
☐ Clotting
☐ Heavy bleeding
☐ Light scanty bleeding
☐ Color
☐ Water retention
☐ Mood changes
☐ Miss periods
☐ Low or no sex drive
☐ Painful breasts
☐ Pelvic pain
☐ Hot flashes
☐ Food cravings
☐ Fallopian tube obstruction
☐ Ovarian Cysts
☐ Endometriosis
☐ Uterine fibroids
☐ Polycystic ovarian syndrome (PCOS)
Other Gynecological Disorders:

Discharges:
☐ Yellow ☐ Thick
☐ White ☐ Odor
☐ Itching ☐ Liquid
Other:
No. Pregnancies
No. Deliveries
No. Miscarriages
No. Abortions
No. Cesareans

Operations:
☐ Cervix
☐ Uterus
☐ Ovaries
Other:

Office Use Only below

---------- TONGUE & PULSE EXAM ----------

Tongue (舌诊)

Body (舌质)

Color: ☐ Pale 淡白 ☐ Light Red 淡红 ☐ Red 红 ☐ Crimson 绛 ☐ Purple 紫 ☐ Bluish 青

Shape: ☐ Tender 嫩 ☐ Old 老 ☐ Fat 胖 ☐ Thin 瘦 ☐ Withered 枯 ☐ Cracked 裂 ☐ Thorny 刺 ☐ Spots 点 ☐ Teeth marks 齿痕

Movement: ☐ Flaccid 痿 ☐ Stiff 强 ☐ Deviated 歪 ☐ Trembling 颤 ☐ Protruding 吐 ☐ Swollen 肿 ☐ Shortened 短缩

Coating (舌苔)

Color: ☐ White 白 ☐ Yellow 黄 ☐ Gray 灰 ☐ Black 黑

Quality: ☐ Thin 薄 ☐ Thick 厚 ☐ Dry 燥 ☐ Moist 润 ☐ Wet 湿 ☐ Greasy 腻

☐ Sticky 粘 ☐ Rough 腐 ☐ Peeled 剥 ☐ Mirror 镜 ☐ Geographic 地图

Sublingual Vessels (舌下络脉)

☐ Normal 正常 ☐ Pale 淡 ☐ Dark 暗 ☐ Purple 紫 ☐ Distended 曲张 ☐ Nodular 结节

Pulse (脉象)

Right (右手):☐ Superficial 浮 ☐ Deep 沉 ☐ Slow 迟 ☐ Rapid 数 ☐ Deficient 虚 ☐ Excess 实

☐ Slippery 滑 ☐ Hesitant 涩 ☐ Wiry 弦 ☐ Thready 细 ☐ Flooding 洪 ☐ Soft 濡

☐ Long 长 ☐ Short 短 ☐ Knotted 结 ☐ Intermittent 代 ☐ Abrupt 促

Left (左手):☐ Superficial 浮 ☐ Deep 沉 ☐ Slow 迟 ☐ Rapid 数 ☐ Deficient 虚 ☐ Excess 实

☐ Slippery 滑 ☐ Hesitant 涩 ☐ Wiry 弦 ☐ Thready 细 ☐ Flooding 洪 ☐ Soft 濡

☐ Long 长 ☐ Short 短 ☐ Knotted 结 ☐ Intermittent 代 ☐ Abrupt 促