West Meets East Acupuncture, LLC
Integrated Healthcare Solutions
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Convenient Chicago Locations

Today's Date: _____

Name: _____ DOB ___/ ___/____ Sex: M F

Address: _____ City _____ State: ____ Zip: _____

Best Phone Number: _____ Alternate Number: _____

Email Address:

_____

Emergency Contact Name & Number:

_____

Occupation: _____ Height: _____ Weight: _____lbs.

Name of your physician:

_____

1. What brought you here today?

_____

2. When did you first notice this problem? What symptoms did you notice?

_____

_____

3. What previous medical tests, diagnosis and/or treatment have you had for this problem? How has treatment helped?

_____

_____

4. Please list any allergies to drugs, medications, or food:_____

5. Please list any medications or supplements you are currently taking:

Medication	**How long have you taken it?**	**Dose**

6. Other serious illnesses, surgeries, injuries?

Date	**Injury/Illness/Surgery**	**Treatment Result**

7. Family history

◯ Allergies ◯ Diabetes ◯ Glaucoma ◯ Emotional Difficulties ◯ Seizure Disorders
◯ Heart Problems ◯ Cancer ◯ Stroke ◯ Hypertension/High BP ◯ Tuberculosis

8. Please check any conditions or symptoms that **you presently have** or **have had in the past:**

GENERAL
- ◯ Poor appetite
- ◯ Excess appetite
- ◯ Insomnia
- ◯ Fatigue
- ◯ Night sweats
- ◯ Sweat easily
- ◯ Chills
- ◯ Poor coordination
- ◯ Bleed/bruise easily
- ◯ Catch cold easily
- ◯ Strong thirst

CARDIOVASCULAR
- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Blood clots
- ◯ Palpitations
- ◯ Chest pain
- ◯ Irregular heart beat
- ◯ Cold hands/feet
- ◯ Fainting
- ◯ Difficult breathing
- ◯ Swelling hands/feet
- ◯ Murmur
- ◯ Other_____

FEMALE
- ◯ Frequent urinary tract infection
- ◯ Frequent vaginal infection
- ◯ Pain/itching of genitalia
- ◯ Genital lesions/discharge
- ◯ Pelvic inflammatory disease
- ◯ Irregular/painful periods
- ◯ Abnormal bleeding
- ◯ Hot flashes
- ◯ Ovarian cysts
- ◯ Fibroids
- ◯ Endometriosis
- ◯ STD

SKIN/HAIR
- ◯ Rashes
- ◯ Hives
- ◯ Itching
- ◯ Eczema
- ◯ Psoriasis
- ◯ Acne
- ◯ Dryness
- ◯ Tumors/lumps
- ◯ Dry/brittle nails
- ◯ Yellow nails
- ◯ Foot fungus

RESPIRATORY
- ◯ Asthma
- ◯ Bronchitis
- ◯ COPD
- ◯ Pneumonia
- ◯ Cough
- ◯ Coughing blood
- ◯ Phlegm or congestion
- ◯ Winded easily
- ◯ Tuberculosis
- ◯ Pulmonary edema
- ◯ Whooping cough

NEUROLOGICAL/PSYCHO-EMOTIONAL
- ◯ Seizures
- ◯ Tremors
- ◯ Numbness/tingling of limbs
- ◯ Multiple concussion
- ◯ Facial pain
- ◯ Paralysis
- ◯ Depression
- ◯ Anxiety/Stress
- ◯ Irritability
- ◯ Teeth grinding/clenching
- ◯ Other _____

HEAD/NECK & EARS
- ◯ Dizziness
- ◯ Fainting
- ◯ Neck stiffness/pain
- ◯ Headaches
- ◯ Migraines
- ◯ Ear infection
- ◯ Ringing in ears
- ◯ Decreased hearing
- ◯ Other: _____

GASTROINTESTINAL
- ◯ Nausea
- ◯ Vomiting
- ◯ Diarrhea
- ◯ Blood in stools/b lack
- ◯ Constipation
- ◯ Gas
- ◯ Rectal pain/cramps
- ◯ Hemorrhoids
- ◯ Bad breath
- ◯ Hearburn/acid reflux

INFECTION SCREENING
- ◯ HIV
- ◯ Hepatitis type: _____
- ◯ Chlamydia
- ◯ Gonorrhea
- ◯ Syphilis
- ◯ Genital warts
- ◯ HPV
- ◯ Herpes: oral
- ◯ Herpes: genital
- ◯ Lymes disease

EYES
- ◯ Blurred vision
- ◯ Visual changes
- ◯ Poor night vision
- ◯ Spots
- ◯ Cataracts
- ◯ Glasses/contacts
- ◯ Eye inflammation
- ◯ Other:_____

GENITO-URINARY
- ◯ Kidney stones
- ◯ Pain on urination
- ◯ Frequent urination
- ◯ Blood in urine
- ◯ Urgency to urinate
- ◯ Unable to hold urine
- ◯ Strong smelling urine
- ◯ Other:_____

MUSCULO-SKELETAL
- ◯ Stiff neck/shoulders
- ◯ Low back pain
- ◯ Muscle spasm or cramps
- ◯ Sore, cold, or weak knees
- ◯ Joint pain or stiffness
- ◯ Muscle weakness
- ◯ Fibromyalgia
- ◯ Other: _____

FOR WOMEN:

1. Are you pregnant now? ◯**Yes** ◯**No** ◯**Unsure**

2. Indicate number of occurrences:

Live Births: _____ Pregnancies:_____ Miscarriages:_____ Abortions:_____

3. Age: First period _____ Onset of menopause: (if applicable) _____

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____

5. Any History of an Abnormal Pap Smear? ◯Yes ◯No If so, what / when?_____

6. Is your menses cycle regular? ı Yes ı No a) Average number of days of flow _____
b) Flow ı Normal ı Heavy ı Light
c) Color: ı Normal ı Dark ı Purple ı Light Brown ı Brown

7. Do you have any of the following menstrual/reproduction related signs/symptoms?

◯Cramps ◯PMS ◯Vaginal discharge◯ Difficulty with orgasm ◯Pain with intercourse

◯Nausea ◯Menstrual blood clots ◯Breast distention ◯Spotting between periods ◯Emotional

FOR MEN:

1. Do you have any bothersome urinary symptoms? ◯Yes ◯No

If yes, please describe:

_____

2. Check all that apply:

◯Erectile dysfunction ◯Pain in testicles ◯Difficulty with orgasm ◯Frequent nighttime urination

◯Premature ejaculation ◯Swelling of testicles ◯Low sperm count ◯Dribbling urination/weak stream

3. Do you get up at night to urinate? ◯Yes ◯No ◯How often? _____

4. Have you sought Medical intervention for these problems? If so, when?_____

5. What treatments have you tried for these problems and how successful have they been?_____

Lifestyle:

Smoking: ◯Yes ◯No How often? How much? _____

Alcohol: ◯Yes ◯No How often? How much? _____

Recreational Drug Use: ◯Yes ◯No How often? How much? _____

Nutrition:
What do you typically eat for the following:
Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:_____

How much water do you drink per ?_____

How much caffeine do you drink per day?_____

Exercise:
What is your daily activity level related to your occupation:
◯Sedentary i.e mostly sitting ı somewhat active

◯Moderately active ı very active (moving around or up most of the time)

◯Heavy duty (lifting, moving thingd etc.)

Do you exercise? ◯Yes ◯No What do you do? _____

How often?_____

Is there anything else you think we should know about you in order to provide you with the best care?

_____

_____

_____