COREACUPUNCTURE
health + wellness

Patient Name: _____

What is your main concern for seeking Acupuncture today?

Please tell us on a scale 1-4 if you have experienced any of these

1 = experienced in past year
2 = experienced in past 6 months
3 = experienced in past month
4 = experiencd in past week

Digestion:

1 2 3 4 Constipation
1 2 3 4 Diarrhea
1 2 3 4 Heart Burn
1 2 3 4 Acid reflux
1 2 3 4 Belching
1 2 3 4 Gas
1 2 3 4 Bloating
1 2 3 4 Nausea
1 2 3 4 _____
1 2 3 4 _____
1 2 3 4 _____

Eyes:

1 2 3 4 Dry eyes
1 2 3 4 Blurry vision
1 2 3 4 Poor Night Vision
1 2 3 4 _____
1 2 3 4 _____

Ears:

1 2 3 4 Ringing
1 2 3 4 Loss of hearing
1 2 3 4 Drainage / ear wax
1 2 3 4 _____

Pain:

1 2 3 4 Headaches
1 2 3 4 Ears / nose / throat
1 2 3 4 Chest
1 2 3 4 Shoulders
1 2 3 4 Neck
1 2 3 4 Back
1 2 3 4 Hips
1 2 3 4 Knees
1 2 3 4 other joints
1 2 3 4 feet

Skin:

1 2 3 4 Dry / Flaky
1 2 3 4 Oily
1 2 3 4 Hives / Rashes
1 2 3 4 Acne
1 2 3 4 Eczema

Nose:

1 2 3 4 Dry
1 2 3 4 Bloody Nose
1 2 3 4 Congested
1 2 3 4 Runny

Throat:

1 2 3 4	Infections	1 2 3 4	irritation / dry / scratchy
1 2 3 4	swelling		

Sleep:

How many hours of sleep per night do you get during the week?	<4	4-5	5-6	6-7	8-9	10+
How many hours of sleep per night do you get on the weekend?	<4	4-5	5-6	6-7	8-9	10+

Do you fall asleep easily? Y / N	Do you fall back asleep easily? Y / N
Do you wake up during night? Y / N	How many times? _____
What time do you usually go to bed?	When do you wake?
Do you Dream? Y / N	
Do you sweat easily? Y / N	Do you run hot or Cold compared to others?

Health History:

If Yes please provide details (dates, area of body etc)

Please Circle ALL that have applied or currently apply to you :

High Blood Pressure	Cancer	Smoking
Chicken Pox / measles / mumps	Mono	Hepatitis
Blod Clots	Tuberculosis	Seizures
Alcohol / Drug Addiction	stroke	Heart Condition
Asthma	Allergies	HIV / AIDS

Surgery (list year & type of surgery below)

1)

2)

3)

Female Patients only:

Are you or could you be pregnant?	Y / N	
Start of last menstrual Cycle: / /	# of days in Cycle:	# of flow days?
Cramping? None / Mild / Moderate / Severe	Clots? Y / N	
# of pregnancies?	# of children:	