ACUPUNCTURE WELLNESS CENTER

Jack Tobol, M.AC, A.P

Today's Date: _____________
First Name: _______________ Last Name: __________________
Height: ____' ____" Weight: _____________lbs. __ Male __ Female
Birthdate: _____/_____/______ Age: _____ SS#:_________________
Guardian (if under 18): ______________________________________
Marital Status: __ Single __ Married __ Separated/ Divorced __ Widowed
Mailing Address: ____
City: ______________ State: ________Zip:___________
E-Mail:___________________________
Cell Phone #:______________________
Home Phone #:____________________
Work Phone #:_____________________
Referred By: ___________________
Occupation: ___________________ Employer: ___________________
Employer Address: ____
Health Concern/Reason for Visit:
____
What symptoms are you having:________________________________
____
Does anything limit you from Care? ( ) Y ( ) N If yes, explain: _______
____
Other physicians/ therapists seen for this condition: _________________
____
Medications/Supplements/ Vitamins: _____________________________
____
Allergies: ____
Is This Related to an Automobile Accident? ________
Is This a Worker's Comp Injury? _________________
Please List Past Surgeries: ____
Do you smoke? __________ If Yes, How much ___________________
Do you drink coffee/black tea? If yes, How Much ___________________
Do you use alcohol? _________If Yes, How Much? ___________________
Do you Exercise? If Yes, How often __________________________

How was your childhood health? ___________________________________
____
Hospital Visits/ Stays: ____

Recent tests: (please indicate test result and date below)
__ Physical __ Cholesterol __ Prostate __ Blood (which?)
__ HIV/STD __ Pap smear __ Mammography
__ Other: _________________

Test Results and Date: ____
____

Check any you have had in the past:

__ Diabetes __ Allergies __ Glaucoma __ Rheumatic Fever
__ Stroke __ Heart Disease __ Vein Condition __ Thyroid Disorder
__ Asthma __ Pneumonia __ Tuberculosis __ Emphysema
__ Jaundice __ Gonorrhea __ Mumps __ Bleeding Tendency
__ Syphilis __ Measles __ Chicken Pox __ Nervous Disorder
__ Meningitis __ HIV __ Polio __ Mononucleosis
__ Epilepsy __ High Fever __ Hepatitis __ Multiple Sclerosis
__ Paralysis __ Cancer __ Migraines __ High Blood Pressure

Pleas list you family medical history:
Father: ____
Mother: ____
Siblings: ____
____
Children: ____
____

Check the following that have occurred in your blood relatives:

__ Diabetes __ Cancer __ Heart Disease __ High Blood Pressure
__ Allergies __ Tuberculosis __ Obesity __ Bleeding Tendency
__ Kidney Disease __ Alcoholism __ Nervous Illness __ Mental Illness
__ Stroke

Please check any of the following that pertain to you:

Overall Temperature (Kidney Function):

__ cold hands __ cold feet __ sweaty hands __ sweaty feet
__ hot body temperature (sensation) __ cold body temperature (sensation)
__ afternoon flushes __ night sweats __ heat in hands, feet and chest
__ hot flashes any time of the day __ thirsty
__ perspire easily __ lack of perspiration __ take water to bed
__ difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney function):

__ shortness of breath __ general weakness __ easily catch colds
__ low energy __ feel worse after exercise
__ difficulty keeping eyes open in the daytime

Blood (Liver, Spleen, Heat function):

__ dizziness __ see floating black spots

Heart Function:

__ palpitations __ anxiety __ sores on the tip of the tongue
__ restlessness __ mental confusion __ chest pain
__ frequent dreams __ wake un-refreshed __ drink coffee (# of cups per wk.__)

Lung Function:

__ nasal Discharge __ cough __ nose bleeds __ sinus congestion
__ dry mouth __ dry throat __ dry skin __ allergies
__ alternating fever and chills __ sneezing __ stiff Neck
__ Headache (location: _______________) __ stiff shoulders __ sore throat
__ difficulty breathing __ achy body __ sadness
__ melancholy __ smoke cigarettes (# per day _______)

Spleen Function:

__ low appetite __ abrupt weight gain __ abrupt weight loss
__ abdominal bloating __ abdominal gas __ gurgling in the stomach
__ fatigue after eating __ prolapsed organs __ easily bruised
__ hemorrhoids __ pensive __ over-thinking
__ worry

Spleen, Stomach, Large Intestine, Small Intestine Function:

__ loose stools __ constipated __ incomplete __ diarrhea
__ blood in stools __ mucous in stools
__ undigested food in stools

Dampness Trapped in the body:

__ general sensation of heaviness in the body __ mental sluggishness
__ mental heaviness __ mental fogginess
__ swollen hands __ swollen feet __ swollen joints
__ chest congestion __ nausea __ snoring

Stomach Function:

__ large appetite __ bad breath __ canker sores __ bleeding gums
__ heartburn __ acid reflux __ stomach ulcers __ belching
__ hiccoughs __ stomach pain __ vomiting __ pain after eating

Liver, Gall Bladder Function:

__ chest pain __ tightness in chest __ bitter taste in mouth
__ anger easily __ frustration __ depression
__ irritability __ unable to adapt to stress
__ alternating diarrhea and constipation __ skin rashes
__ headache at the top of the head __ tingling sensation
__ numbness __ muscle spasms __ muscle twitching
__ muscle cramping __ seizures __ convulsions
__ lump in the throat __ neck tension __ shoulder tension
__ drink alcohol __ gall stones __ STD (which one:___________)

Eyes (liver function):

__ itchy __ bloodshot __ hot __ dry
__ watery __ gritty __ blurred vision __ decreased night vision
__ near-sighted __ far-sighted

Kidney, Urinary Bladder Function:

__ frequent cavities __ easily broken bones __ sore knees
__ weak knees __ cold sensation in the knees __ low back pain
__ memory problems __ excessive hair loss __ kidney stones
__ bladder infections __ wake twice or more during the night to urinate
__ lack of bladder control __ fear __ easily startled

Urination:

__ normal color	__ dark yellow	__ clear	__ reddish
__ cloudy	__ scanty	__ profuse	__ strong odor
__ burning	__ painful	__ discharge	__ difficult
__ urgent	__ frequent		

Libido:

__ normal __ high __ low

Women Only:

Regular menstrual cycle? ( ) Y ( ) N
Number of children ______________
Age of first menstruation ___________
Average number of day of flow: _____

Pregnant? ( ) Y ( ) N
Number of pregnancies? ________________
Age of menopause (if applicable): __________
Average number of days in cycle: __________

Do you experience any of the following pre-menstrual syndromes?

__ nausea	__ food cravings	__ depression	__ vomiting
__ headaches	__ irritability	__ water retentions	__ migraines
__ anxiety	__ breast swelling	__ breast tenderness	

__ other emotions: ______________
__ sharp pain, where? ___________
__ dull pain, where? _______________
__ other: _________________________

Men Only:

__ swollen testes __ testicular pain __ impotence
__ premature ejaculation __ feeling of coldness or numbness in external genitalia
__ other: ________________________________

In Case of Emergency:
Contact: ___________________________ Relationship: _______________________
Phone Number: ______________________
Secondary Contact: ___________________ Relationship:________________________
Phone Number: ______________________

Patients Signature: ____