

## ORIENTAL MEDICINE CONSULTATION FORM

Date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex M F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

May we contact you by telephone regarding future appointments? Yes No

Email Address \_\_\_\_\_

May we contact you via email to share clinic news and inform you of upcoming events/classes?

Emergency Contact \_\_\_\_\_

Marital Status: S M D W Number of children \_\_\_\_\_

Occupation \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Who referred you to this office? \_\_\_\_\_

What brought you here today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Main conditions you would like us to help you with, in order of significance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

When did you first notice any problems related to what brought you here today and what symptoms did you notice? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Cloud Gate Acupuncture

What has happened since you first noticed any symptoms and up to today?

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What previous medical workups, diagnosis and treatment have you had for this problem? How have these been helpful or unhelpful?

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Please list any allergies to drugs or medications.

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What medications or supplements are you currently taking?

Medication

Dose

How long have you been taking it

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Smoking: How much per day? \_\_\_\_\_

Alcohol: How much per day? \_\_\_\_\_

## Nutrition

What do you typically eat for the following meals?

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Are you a vegetarian? Yes No Yes, but not so strict

What vitamin/nutritional supplements are you currently taking?

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## Exercise

What is your daily activity level related to your occupation?

- Sedentary (mostly sitting)
- Moderately active
- Heavy duty (lifting, moving things, ect.)
- Somewhat active
- Very active (moving around most of the time)

What kind of physical activity level (exercise/sports) do you participate in? How often per week?  
How long each time?

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How much water do you drink per day? \_\_\_\_\_

How many caffeine containing products (coffee, tea, carbonated pop) do you drink per day?

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What kinds of snacks do you typically eat? \_\_\_\_\_

Other illnesses, surgeries, injuries

### **Illnesses**

<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### **Surgeries**

<u>Year</u>	<u>Surgery</u>	<u>Outcome</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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## Injuries or Traumas

<u>Year</u>	<u>Injury/Trauma</u>	<u>Treatment</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Family History

- Allergies     Diabetes     Emotional Difficulties     Glaucoma     Heart Problems  
 Stroke     Cancer     Seizure Disorders     Thyroid Problems  
 Hypertension/ High BP     Tuberculosis     Substance Abuse

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

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>		<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Cough	<input type="radio"/>	<input type="radio"/>	Irregular heartbeat	<input type="radio"/>	<input type="radio"/>
Cough with blood	<input type="radio"/>	<input type="radio"/>	Poor circulation	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>	Fainting spells	<input type="radio"/>	<input type="radio"/>
Seasonal allergies	<input type="radio"/>	<input type="radio"/>	Chest pains	<input type="radio"/>	<input type="radio"/>
Frequent colds	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>
Nasal or sinus congestion	<input type="radio"/>	<input type="radio"/>	Varicose veins	<input type="radio"/>	<input type="radio"/>
Sinus infections	<input type="radio"/>	<input type="radio"/>	Low Blood Pressure	<input type="radio"/>	<input type="radio"/>
Loss of smell	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
			<b>**Treatment</b>		
Pneumonia	<input type="radio"/>	<input type="radio"/>			
Sputum/phlegm	<input type="radio"/>	<input type="radio"/>	Fatigue	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Weight loss	<input type="radio"/>	<input type="radio"/>
Lack of perspiration	<input type="radio"/>	<input type="radio"/>	Weight gain	<input type="radio"/>	<input type="radio"/>
Excessive perspiration	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Nose bleeds	<input type="radio"/>	<input type="radio"/>	Poor appetite	<input type="radio"/>	<input type="radio"/>
Nasal polyps	<input type="radio"/>	<input type="radio"/>	Excessive appetite	<input type="radio"/>	<input type="radio"/>
Indigestion	<input type="radio"/>	<input type="radio"/>	Abdominal cramping	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	Abdominal pain	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

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Vomiting

Vomiting with blood

Gas

Bloating

Belching

Acid regurgitation

Frequent urination

Excessive urination

Nighttime urination

Unable to hold urine

Kidney stones

Bladder infections

Diarrhea

Constipation

\*\*Laxative use: Y N

\*\*Product \_\_\_\_\_

Alternating diarrhea/constipation

Hemorrhoids

Blood in stool

Bowel movements every \_\_\_\_\_ days  
\_\_\_\_\_ number of bowel movements/day

Burning on urination

Difficulty urinating

Painful urination

Blood in urine

Sexually transmitted diseases \_\_\_\_\_

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Muscle pain	<input type="radio"/>	<input type="radio"/>
Muscle weakness	<input type="radio"/>	<input type="radio"/>
Muscle spasms	<input type="radio"/>	<input type="radio"/>
Back pain (lower)	<input type="radio"/>	<input type="radio"/>
Back pain (middle)	<input type="radio"/>	<input type="radio"/>
Back pain (upper)	<input type="radio"/>	<input type="radio"/>
Pain goes down legs	<input type="radio"/>	<input type="radio"/>

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Joint pain	<input type="radio"/>	<input type="radio"/>
**Where?		
Neck pain	<input type="radio"/>	<input type="radio"/>
Knee pain	<input type="radio"/>	<input type="radio"/>
Numbness	<input type="radio"/>	<input type="radio"/>
**Where?		

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Wear glasses	<input type="radio"/>	<input type="radio"/>
Blurred vision	<input type="radio"/>	<input type="radio"/>
Double vision	<input type="radio"/>	<input type="radio"/>
Cataracts	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>
Eyes feel swollen	<input type="radio"/>	<input type="radio"/>
Pressure in eye	<input type="radio"/>	<input type="radio"/>
Eye pain	<input type="radio"/>	<input type="radio"/>

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Eye tiredness/strain	<input type="radio"/>	<input type="radio"/>
Seeing spots	<input type="radio"/>	<input type="radio"/>
Sensitivity to light	<input type="radio"/>	<input type="radio"/>
Eye dryness	<input type="radio"/>	<input type="radio"/>
Eye redness	<input type="radio"/>	<input type="radio"/>
Eye itchiness	<input type="radio"/>	<input type="radio"/>
Eye tearing	<input type="radio"/>	<input type="radio"/>

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Hearing difficulties	<input type="radio"/>	<input type="radio"/>
Ringing in the ears	<input type="radio"/>	<input type="radio"/>
Ear pain	<input type="radio"/>	<input type="radio"/>
Nasal polyps	<input type="radio"/>	<input type="radio"/>

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Loss of balance	<input type="radio"/>	<input type="radio"/>
Ear infections	<input type="radio"/>	<input type="radio"/>
Jaw clicks	<input type="radio"/>	<input type="radio"/>
Tooth problems	<input type="radio"/>	<input type="radio"/>

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Sore throats	<input type="radio"/>	<input type="radio"/>

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Sore gums	<input type="radio"/>	<input type="radio"/>

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Mouth dryness	<input type="radio"/>	<input type="radio"/>	Bleeding gums	<input type="radio"/>	<input type="radio"/>
Bad taste in mouth	<input type="radio"/>	<input type="radio"/>	Sore tongue	<input type="radio"/>	<input type="radio"/>
Bad breath	<input type="radio"/>	<input type="radio"/>	Numbness of tongue	<input type="radio"/>	<input type="radio"/>
Mouth sores/ulcerations	<input type="radio"/>	<input type="radio"/>	Grinding teeth	<input type="radio"/>	<input type="radio"/>
Changes in skin color	<input type="radio"/>	<input type="radio"/>	Dandruff	<input type="radio"/>	<input type="radio"/>
Skin bruising	<input type="radio"/>	<input type="radio"/>	Eczema	<input type="radio"/>	<input type="radio"/>
Skin rashes	<input type="radio"/>	<input type="radio"/>	Psoriasis	<input type="radio"/>	<input type="radio"/>
Skin acne	<input type="radio"/>	<input type="radio"/>	Skin ulcerations	<input type="radio"/>	<input type="radio"/>
Sudden weight loss	<input type="radio"/>	<input type="radio"/>	Sudden weight gain	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Thyroid disorder	<input type="radio"/>	<input type="radio"/>

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>		<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Anxiety	<input type="radio"/>	<input type="radio"/>	Alcohol abuse	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	Drug abuse	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>			
Hot tempered	<input type="radio"/>	<input type="radio"/>	Psychological crisis	<input type="radio"/>	<input type="radio"/>
Stress	<input type="radio"/>	<input type="radio"/>	Emotional difficulties	<input type="radio"/>	<input type="radio"/>
Crying easily	<input type="radio"/>	<input type="radio"/>	Psychoactive meds	<input type="radio"/>	<input type="radio"/>
			**if yes, which ones?	_____	
Fevers	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>	Concussion	<input type="radio"/>	<input type="radio"/>
Cold intolerance	<input type="radio"/>	<input type="radio"/>	Headache	<input type="radio"/>	<input type="radio"/>
General chilliness	<input type="radio"/>	<input type="radio"/>	Shaking / tremors	<input type="radio"/>	<input type="radio"/>
Cold hands / feet	<input type="radio"/>	<input type="radio"/>	Cysts / tumors	<input type="radio"/>	<input type="radio"/>
Heat intolerance	<input type="radio"/>	<input type="radio"/>	Edema	<input type="radio"/>	<input type="radio"/>
General warmth	<input type="radio"/>	<input type="radio"/>	Water retention	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	Night sweating	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Insomnia	<input type="radio"/>	<input type="radio"/>
Poor memory	<input type="radio"/>	<input type="radio"/>	Nightmares	<input type="radio"/>	<input type="radio"/>
			Sleepwalking	<input type="radio"/>	<input type="radio"/>

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**Male Patients:** Please fill out the following section.

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

	<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>		<u>Presently</u> <u>Have</u>	<u>Had in</u> <u>Past</u>
Prostate enlargement	<input type="radio"/>	<input type="radio"/>	Premature ejaculation	<input type="radio"/>	<input type="radio"/>
Prostatitis	<input type="radio"/>	<input type="radio"/>	Impotence	<input type="radio"/>	<input type="radio"/>

**Female Patients:** Please fill out the following section.

Pregnancy

Are you presently pregnant?      Y      N      Not sure

Please list your history of pregnancy. Note if full term (FT), premature (P), miscarriage (MC), abortion (A) whether vaginal (V) or Cesarean section (CS). Note any difficulties you experienced during the pregnancy and/or after delivery (for example: morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)

Year

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Menstruation

Age of onset \_\_\_\_\_ Last Menstrual Period (first day of) \_\_\_\_\_

Date of last Pap exam \_\_\_\_\_ Result \_\_\_\_\_

Length of time between periods \_\_\_\_\_

Are you taking birth control? If yes, what kind and for how long? \_\_\_\_\_

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Regularity:

- Regular    Irregular    Usually early by \_\_\_\_ days    Usually late by \_\_\_\_ days    Varies between being early or late

How many days of menstrual flow do you usually have? \_\_\_\_\_

Flow is:    Even    Uneven    Heavy    Light

Average number of pads used per day \_\_\_\_\_

Color is:    Pale    Pink    Light Red    Red    Deep Red    Purplish    Brown

Consistency is:    Thin    Thick    Clotted

### Discomfort with period:

Lower abdominal distention    before    during    after menstruation

Lower back soreness    before    during    after menstruation

Cramping    before    during    after menstruation

### Premenstrual Syndrome (PMS)

- Irritability    bloating    mood swings    breast tenderness

Other: \_\_\_\_\_

Vaginal Discharge   Yes   No

If yes, color and amount: \_\_\_\_\_

### Menopause

Age of onset \_\_\_\_\_

Any difficulties / symptoms? \_\_\_\_\_

Uterine bleeding (not related to periods)   Yes   No

Color and amount \_\_\_\_\_

Please mark any that apply:

Fibroids    Ovarian cysts    Irregular periods

Breast lumps    Infertility    Hot flashes

Vaginal infections    Pelvic Infection    Endometriosis

Painful Periods