

Fusion Health Acupuncture Clinic

NANCY NGUYEN, LAc, Dipl OM, LMT

Name: _____ Date: _____ DOB: _____ Sex: _____

Marital Status: _____ #children: _____ Occupation: _____ Ht/Wt: _____

Address: _____ City, State, Zip _____

Email Address: _____ Referred by: _____

Phone Work: _____ Home: _____

Emergency Contact Name/Relation: _____ Phone: _____

Have you ever had acupuncture before? Y N Chinese Herbs? Y N

Are you under the care of a physician? Y N Physician Name: _____

What would you like to be treated for? _____

How long have you had this condition? _____

Aggravating factors: _____

Ameliorating factors: _____

Current Medications/other therapies (please state dosage and duration): _____

Medical History (please check conditions you currently have or had in the past):

- | | | | | |
|--|---|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Nephritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid Dysfunction | |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> GI problems | <input type="checkbox"/> Surgery | |

Other/Notes: _____

Family Medical History:

- | | | | | |
|---|--|-----------------------------------|--|---------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | | |

Other/Notes: _____

PLEASE CHECK ALL THAT APPLY TO YOU.

Lifestyle:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> cigarettes | <input type="checkbox"/> alcohol | <input type="checkbox"/> recreational drugs |
| <input type="checkbox"/> caffeine | <input type="checkbox"/> occupational hazards | <input type="checkbox"/> exercise |

Other/Notes: _____

General:

poor appetite insomnia disturbed sleep nightmares
 food cravings weight gain weight loss changes in appetite
 unquenchable thirst energy fluctuations abnormal bleeding/bruising
 sweating easily night sweats fever chills

Other/Notes: _____

Skin/Hair:

rashes/hives ulcers acne/boils fungal infections
 itching new moles dry skin dandruff
 hair loss hair/skin changes

Other/Notes: _____

Head:

dizziness/vertigo concussions migraines/headaches
 night blindness seeing spots/stars poor vision redness of eyes
 cataracts eye strain/pain poor hearing ringing in ears
 earaches/infections sinus problems nose bleeds sore throat
 clench/grind teeth sores/ulcers mouth/lips facial pain/twitches
 excessive saliva excessive phlegm teeth/gum problems

Other/Notes: _____

Respiratory:

shortness of breath asthma/wheezing cough tightness of chest
 difficulty breathing lying down

Other/Notes: _____

Cardiovascular:

palpitations chest/rib pain high blood pressure low blood pressure
 irregular heartbeat high cholesterol recent heart attacks recent strokes

Other/Notes: _____

Musculoskeletal/Neurological:

whole body pain one sided weakness/pain general weakness localized weakness
 chronic pain acute pain joint pain inflammation
 numbness/tingling loss of coordination loss of balance twitching
 facial tics seizures

Other/Notes: _____

Psychological:

anger sadness/depression thoughts of suicide
 mood swings irritability anxiety abuse survivor

Other/Notes: _____

Gastrointestinal:

nausea vomiting belching gas
 bloating indigestion heartburn diarrhea
 abdominal pain/cramps constipation blood in stool black stool
 hemorrhoids itchy anus irregular bowel movements

Other/Notes: _____

Genitourinary:

pain upon urination frequent urination(>10x/day) blood urination
 night urination abnormal color urgent urination difficult urination
 incontinence genital sores genital itching abnormal discharge
 incomplete urination impotence premature ejaculation enlarged prostate

Other/Notes: _____

Reproductive/Gynecological:

irregular menstrual cycle pain/cramping mood swings water retention
 abnormal bleeding menstrual clots breast tenderness breast distention
 pregnancy complications infertility hysterectomy menopause

Age of first menses: _____ yrs Complete cycle: _____ days Menstruation: _____ days

1st day of last menses: _____ #of pregnancies: _____ # of births: _____

Are you or could you be pregnant? _____ *if so, how far along?* _____

Birth control methods: _____

Other/Notes: _____

Any other issues you would like to discuss: _____

PLEASE STOP HERE.

Notes: _____

Tongue: _____

Pulse: L: _____ / _____ / _____

R: _____ / _____ / _____

Diagnosis: _____

Treatment Plan: _____

Acu TX: _____

Herbal TX : _____

Suggestions/Comments/Referrals: _____

Practitioner signature: _____

Date: _____