Acupuncture by Devon

Name _____ Age _____ Date _____

Directions: Please number the boxes with the appropriate grading scale.
1 = SEVERE (once or more per week)
2 = MODERATE (every couple of weeks)
3 = MILD (once per month)

Earth

__ Indigestion, gas, bloating, heartburn, reflux
__ Stomach distension or pain
__ Nausea
__ Appetite is __ good ___ poor

__ Stools are ___ loose ___ soft ___ well formed
__ Bowel movements ___ times daily
__ Blood in stools

__ Frequent over-thinking, frequent worrying
__ Weakness of arms and legs
__ Chronic hemorrhoids
__ Feel sleepy, tired after eating
__ Difficulty losing or gaining weight
__ Phlegm or mucous in nose, ears (wax)
__ Lots of thin, clear mucous
__ Yellow or green phlegm
__ Frequent gurgling sounds in stomach
__ Undigested food in stools
__ Sweet taste in mouth
__ Craving for sweets
__ Dry, cracked lips
__ Mouth sores or bleeding gums
__ Toothaches
__ Headaches at forehead
__ Dry heaves or hiccups

Wood

__ Irritability, frequent moodiness, anger
__ Impetuosity, depression, mental restlessness
__ Tight feeling in chest or side of trunk, breasts
__ Frequent sighing or need to take a deep breath

__ Burping, belching, frequent hiccups
__ Stools hard like little pebbles or long and thin
__ Eye redness or pain

__ Headaches on temples, top or back of head
__ Sudden dizziness or vertigo
__ High pitched ringing in ears
__ Blurred vision, eye floaters, poor night vision
__ Dizziness when getting up or after exertion
__ Brittle nails or dry skin
__ Twitching muscles or eyelids
__ Numbness of limbs
__ Tremors, convulsions
__ Sudden hearing loss, ear pain
__ Genital itching, swelling or pain
__ Easily startled
__ Dream disturbed sleep
__ Bitter taste in mouth
__ Feeling of lump in throat, difficult swallowing
__ "Liver" spots, varicosities

Metal

__ Respiratory Problems
__ Sinus Problems
__ Allergies, sinus congestion
__ Hands and feet go to sleep easily
__ Fevers, colds & flu, sore throat
__ Cough
__ Phlegm is __ clear __ yellow
__ Phlegm is __ thick ___ watery
__ Spontaneous sweating
__ Chronic asthma
__ Fatigue and dislike of talking
__ Facial edema or swelling
__ Frequent colds
__ Asthma, harder to exhale than inhale
__ Prefer open windows in a closed room

Fire

__ Palpitations (can feel heart beating in chest)
__ Insomnia, difficulty falling asleep
__ Insomina, difficulty staying asleep
__ Perspiration or palpitations with excitement
__ Discomfort at high altitude
__ Get drowsy often
__ Unsettled or anxious
__ Dry mouth and throat
__ Tongue sores
__ Chest pain or stifling sensation in chest
__ Circulation problems
__ Skin rash that is red, burning or itching
__ Burning urination

Water

__ Hearing loss
__ Ear ringing
__ Low back pain
__ Knee pain
__ Cold feet
__ Crave salt
__ Feel cold easily
__ Darkness under eyes
__ Failing memory
__ Low blood pressure
__ High blood pressure
__ Hair thinning or loss, early gray hair

__ Frequent urination, incontinence or dribbling
__ Frequent night urination

__ Color of urine is __ pale __ yellow __ dark yellow
__ Urine is __ clear __ cloudy or turbid
__ Asthma, harder to inhale than exhale
__ Difficulty breathing when lying down
__ Flushed face easily
__ Bone or joint problems

__ Early morning diarrhea or chronic diarrhea
__ Prolonged physical or emotional stress
__ History of blood loss
__ Night sweats or hot flashes, flushed face
__ Increased or reduced sex drive
__ Low grade fever
__ Frequent terror, fear or fright
__ Poor memory

History of back pain in family? If yes,
__ mother
__ father

__ grandparents

Check if you have been diagnosed with:

__ Thyroid disease
__ Liver trouble
__ Diabetes
__ Gallbladder Problems
__ Cardiovascular disease
__ Irritable Bowel Syndrome
__ Any kind of Arthritis
__ Kidney trouble
__ Ulcers
__ Fibromyalgia

Women

__ Started menstruation at age ____
__ Cycle is ___ days
__ Menstrual flow lasts ___ days
__ Yeast or other genital infections
__ Clear watery vaginal discharge
__ Thick or yellow vaginal discharge
__ Irregular menses
__ Taking birth control pills
__ Heavy menstrual bleeding
__ Dark menstrual blood with clots
__ Bright red menstrual blood
__ Pale color menstrual blood

__ Spotting or dribbling for many days
__ Menstrual pain before, during, or after period

__ Menstrual low back pain
__ Short/early cycle
__ Long/delayed cycle
__ Post or pre-menstrual symptoms
__ Frequent painful or swollen breasts
__ Cysts, lumps, turners

__ Menopause started at age ___

Men

__ Prostrate trouble
__ Dribbling urination
__ Weak or slow urine stream
__ Testicular swelling or pain
__ Difficulty with erections
__ Urethral trouble or discharge

Please list any medications you are taking:

Please list any nutritional supplements you are taking:

Patient Name _____ Date _____

Please list any surgeries, accidents, or injuries Date Physicians notes

1 _____ _____ _____

2 _____ _____ _____

3 _____ _____ _____

4_____ _____ _____

List of allergies or sensitivities

_____

_____

_____

_____

Is there a family history of any of the following (Please check and indicate which family member)										
	Y	N	Who		Y	N	Who		Y	N	Who
Heart disease				Migraines				Osteoporosis			
High blood press.				Diabetes				Alzheimer's			
Low blood press.				Hepatitis				Parkinson's			
High cholesterol				Cancer				Thyroid Prob.			
Emotional prob.				Asthma				Arthritis			
Obesity				Anemia				AIDS/HIV			
Others:											
Have you had any of the above illnesses?											

Please indicate any use of the following							
			Frequency and amount				Frequency and amount
	Y	N			Y	N	
Tobacco				Soda Regular			
Coffee Regular				Soda Diet			
Coffee Decaf				Sweets and desserts			
Tea Caffeinated				Recreational Substances			
Tea decaf				Water			
Alcohol				Meditation			