Healing Horizons

Integrated Health Solutions

Acupuncture Symptom Survey

Name: _____ **Age:** _____ **Date:** _____

This survey will allow your practitioner to evaluate your whole person more completely in order to provide you with individualized care. All information will be held confidential.

What are your primary health concerns for which you are seeking treatment?

1. _____ **2.** _____ **3.**_____

Do you have a primary care physician? Please name: _____

Have you received any prior treatment for the above complaints? If so, please list the nature of the treatment(s), the approximate date(s), and whether or not it was helpful:

_____

_____

_____

_____

Have you had any Western medical tests such as x-rays, MRI's, or blood tests for the above complaints? Please indicate the results and the approximate dates below:

_____

_____

_____

_____

Do you have any known allergies?

Food: _____ MSG: _____

Medications: _____ Chemicals: _____

Pollens: _____ Other: _____

Pet: _____ _____

Subjectively, does your body normally run hot or cold? _____

****On the next two pages, please place a check mark next to those symptoms which you NOW experience or have experienced in the PAST. If there are one or more words in a line which describe your specific symptoms,* ***please circle those words.***

GENERAL SYMPTOMS	NOW	PAST	GENERAL SYMPTOMS	NOW	PAST
Tired, weak, low energy			Sweat too much/too little		
Depression, irritability			Night sweats		
Worry, anxiety, nervousness			Dizziness, fainting, convulsions		
Sleeplessness, sleep too much			Loss of weight, weight gain		
Headaches, migraines			Other:		
EYES	**NOW**	**PAST**	**EARS**		
Blurred vision			Earaches		
Dryness, burning, itchy			Ear ringing		
Bloodshot, redness, puffy			Ear discharge, excess wax		
Floaters			Loss of hearing		
Other:			Other:		
NOSE AND THROAT	**NOW**	**PAST**	**RESPIRATORY**	**NOW**	**PAST**
Dry mouth or nose			General shortness of breath		
Nose bleeds			Shortness of breath on exertion		
Dry lips			Spitting or coughing up mucus		
Sore throat			Spitting or coughing up blood		
Clear throat frequently			Chest tightness		
Sore, red, or cracked tongue			Chest pain		
Cold sores, herpes			Other:		
Inability to smell or taste					
Bleeding gums					
Other:					
SKIN AND HAIR	**NOW**	**PAST**	**SKIN AND HAIR**	**NOW**	**PAST**
Acne, pimples			Numbness/tingling		
Skin rashes			Burning sensation in feet		
Hives, itchy skin			Athletes foot		
Skin ulcers or sores			Hair loss, hair thinning		
Dryness, roughness, scaling skin			Dry hair, coarse hair		
Brown spots			Bruise easily		
Moles, warts			Other:		

Other:			**GASTROINTESTINAL**	**NOW**	**PAST**
GASTROINTESTINAL	**NOW**	**PAST**	Diarrhea or loose stools		
Loss of appetite			Constipation		
Difficulty swallowing			Alternating diarrhea/constipation		
Nausea, vomiting			Light colored or greasy stools		
Bad breath			Dark stools		
Metallic or bitter taste in mouth			Blood in stools		
Food cravings			Undigested food in stool		
Heartburn			Foul odor of stool or gas		
Indigestion			Hemorrhoids		
Heaviness after eating			Avoidance of certain foods		
Gas, bloating, belching			Gallbladder stones		
Tender or painful abdomen			Pain under ribs		
Symptoms relieved by eating			Other:		
Symptoms worse after eating					

CARDIOVASCULAR	**NOW**	**PAST**	**URINARY**	**NOW**	**PAST**
Leg pains when walking			Bladder infection		
Varicose veins/spider veins			Kidney infection		
Tendency towards anemia			Kidney stones		
High/Low blood pressure			Low back pain		
Other:			Other:		
MUSCULOSKELETAL	**NOW**	**PAST**	**HABITS**	**NOW**	**PAST**
Muscle stiffness			Cigarettes/tobacco		
Swollen, painful, stiff joints			Amount per day		
Bone pain			Coffee or black tea		
Tremors, twitches			Amount per day		
Loss of strength			Alcohol: Amount per day		
Hernia			Amount per week		
Muscle wasting			Marijuana or other drugs		
Broken bones			Amount per week		
Other:			Soda: Amount per day		

Circle areas of pain below:			Artificial sweeteners_____ Amount per day_____ **FEMALE PATIENTS**_____ Irregular menstruations_____ Pain prior to menses_____ Depressed/irritable with menses_ Painful or swollen breasts_____ Discharge from breasts_____ Lumps in breasts_____ Hot flashes	_____ _____ **NOW**___ _____ _____ _____ _____ _____ _____	_____ _____ **PAST**___ _____ _____ _____ _____ _____ _____
MALE PATIENTS	**NOW**	**PAST**	Diminished sexual desire		
Prostate problems			Excessive sexual desire		
Discomfort in genital area			Date of last period:		
Pain in genital area			Number of days:		
Diminished sexual desire			Length of cycle:		
Excessive sexual desire			Date of last pap smear:		
Difficulty maintaining an erection			Was it normal? Yes No		
Penile discharge			Birth control now? Yes No		
Other:			Method?		
OCCUPATIONAL ENVIRONMENT	**YES**	**NO**	Past methods used:		
Heavy lifting			Currently pregnant? Yes No		
Work stress					
Work related trauma(s)					
Comments regarding above:			**DISEASE/DISORDER**	**YOU**	**FAMILY**
			Learning problems		
			Obsessions		
DISEASE/DISORDER	**YOU**	**PAST**	Thinking problems		
Addiction			Schizophrenia		
Anorexia			Suicide		
Anxiety disorder			Physical health problems		
Attention deficit			Loss or trauma		
Bulimia			Victim of a crime		
Bi-polar			Marital problems		
Compulsions			Parent/child problems		
Depression			Other:		

Have you been exposed in significant or long term doses of chemicals, radiation, toxins, or other? If so, please explain:_____

Please indicate any incidents (and approximate dates) for which you may have had surgery or have been hospitalized for a serious accident or illness:_____

_____

_____

_____

_____

Do you have any chronic illnesses? If so, please explain: _____

_____

_____

Do you have any contagious diseases? If so, please list:_____

_____

_____

Have you traveled outside of the USA within the last two years? Where? _____

_____

_____

Height: _____ Current weight: _____ Past maximum weight: _____ When: _____

Are you happy with your current weight? _____ Most recent blood pressure reading: _____

Vitamins (please list)

_____

_____

_____

_____

Over the counter supplements (please list)

_____

_____

_____

_____

Prescription medication(s) and dosage(s):

_____

_____

_____

_____

_____

Please describe your current diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

_____

What is your current exercise pattern? What physical activities do you enjoy? _____

_____

_____

_____