Text

Davenport Acupuncture

Traditional Chinese Medicine

Paul Revere Square • 2322 East Kimberly Road • Suite 240 West • Davenport, Iowa 52807

Name ____________________ Home Phone ____________________
Street ____________________ City ____________________ State ________ Zip ________
Age ________ Date of Birth ____________________ Place of Birth ____________________
Occupation ____________________ Work Phone ____________________ Retired ____________
Email ____________________ In Emergency Notify ____________________
Referred by ____________________ Family Physician ____________________
Reason for your visit ____________________

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____

PAST MEDICAL HISTORY

___ Allergies
___ Asthma, COPD
___ Cancer
___ Childhood illnesses __________
___ Depression
___ Diabetes
___ Gallbladder disease
___ GERD
___ Heart disease, stroke
___ Hepatitis, liver disease
___ High blood pressure
___ HIV/AIDS
___ Kidney stone
___ Rheumatic fever
___ Seizures
___ Surgeries & Dates ___________
____
____
___ STD ____________________
___ Thyroid disease
___ Vaccinations
___ Other significant illness
____
___ Significant traumatic injury
____
___ Other ____________________
____

FAMILY MEDICAL HISTORY

___ Allergies
___ Asthma, COPD
___ Cancer
___ Diabetes
___ Heart disease, stroke
___ High blood pressure
___ Liver disease
___ Seizures
___ Other ____________________

CURRENT GENERAL HEALTH INDICATORS – PLEASE CHECK ALL THAT APPLY

___ Cold abdomen
___ Cold back
___ Cold hands/feet
___ Chills
___ Cravings
___ Disturbed sleep
___ Easy bleeding/bruising
___ Fatigue
___ Fevers
___ Headaches
___ Heavy sleep
___ Lack of concentration
___ Night sweats
___ Pain
___ Poor appetite
___ Poor balance
___ Poor coordination
___ Poor memory
___ Sensitive to smells or tastes
___ Sudden drop in energy:
Time ____________________
___ Weight gain/loss
___ Changes in bowels
___ Changes in urination
___ Any other unusual or abnormal condition
____

LIFESTYLE AND HABITS

Exercise ____________________ Other, i.e. yoga, tai chi ____________________
Occupational stress factors ____________________
Habitual consumptions: ___ Cigarettes ___ Alcohol ___ Coffee, tea, soda ___Other ____________________
Dietary Considerations ____________________
Medications and/or supplements ____________________

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SKIN AND HAIR

___ Easy bruising
___ Eczema
___ Hives
___ Itching
___ Pimples
___ Psoriasis
___ Rashes
___ Ulcerations
___ Dandruff
___ Hair Loss
___ Recent changes in hair/skin texture
___ Other ________________________
____
____

HEAD, EYES, EAR, NOSE, THROAT

___ Concussions
___ Dizziness
___ Facial Pain
___ Headaches: where ___________
frequency ________
___ Migraines
___ Black spots, floaters
___ Cataracts
___ Color blindness
___ Dry eyes, itchy eyes
___ Eye pain
___ Glasses
___ Poor vision
___ Earaches
___ Ringing in the ears
___ Nose bleeds
___ Sinus problems
___ Copious saliva
___ Dry mouth
___ Dry throat
___ Grinding teeth
___ Sores on lips, tongue
___ Recurrent sore throat
___ Teeth, gum problems

CARDIOVASCULAR

___ Blood clots
___ Chest pain or pressure
___ Chest tightness
___ Cold hands or feet
___ Difficulty breathing
___ Dizziness
___ Fainting
___ Irregular heartbeat
___ High blood pressure
___ Low blood pressure
___ Pain in legs with walking
___ Phlebitis
___ Spontaneous sweating
___ Swelling of feet
___ Swelling of hands
Any other cardiac problems ____

RESPIRATORY

___ Asthma
___ Bronchitis
___ Color of mucus
___ Cough
___ Coughing up blood
___ Coughing up mucus
___ Difficulty breathing
___ Difficulty exhaling
___ Difficulty inhaling
___ Easily sweat
___ Frequent colds
___ Pain with inhalation
___ Pneumonia
___ Thick mucus
___ Thin mucus
Any other lung problems ____

GASTROINTESTINAL

___ Abdominal cramps or pain
___ Always feel hungry
___ Belching
___ Black stools
___ Bloating
___ Blood in stools
___ Constipation
___ Diarrhea
___ Easily full when eating
___ Food sensitivities
___ Gas
___ Hemorrhoids
___ Indigestion, heartburn
___ Laxatives
___ Mucus in stools
___ Nausea / Vomiting
___ Rectal pain
___ Stomach always grumbling
Any other GI problems ____

GENITOURINARY

___ Blood in urine
___ Cloudiness
___ Color of urine ___________
___ Decrease in flow
___ Dribbling
___ Frequent urination
___ Incontinence
___ Pain with urination
___ Strong odor to urine
___ Waking at night to urinate
___ Decreased libido
___ Increased libido
___ Early ejaculation
___ Impotence
___ Itching genitals
___ Sores on genitals
___ Sweating in genitals
___ Kidney stones
Any other genitourinary problems ____

REPRODUCTIVE AND GYNECOLOGICAL

Age at menarche ___________
Length of cycle ____________
Length of menses __________
___ Back pain with menses
___ Bleeding between menses
___ Clots
___ Color of flow _____________
___ Diarrhea with menses
___ Headache with menses
___ Heaviness in pelvis

___ Irregular menses
___ No menses
___ Nosebleed with menses
___ Painful menses
___ PMS
___ Strong odor
___ Vaginal discharge
___ Vaginal odor
___ Breast lumps, swelling, discharge

___ Birth control
___ Miscarriages, abortions _____
___ Pregnancies: how many _____
___ Premature births ___________
___ Infertility
___ Infertility treatments _______
____
____
___ Surgeries __________________
____

Any other gynecological problems ____

MUSCULOSKELETAL

___ Ankle, foot pain
___ Back pain
___ Fibromyalgia
___ Hip pain
___ Leg pain
___ Knee pain

___ Muscle pain
___ Muscle weakness
___ Neck pain
___ Numbness, location _________
___ Osteoarthritis
___ Rheumatoid arthritis

___ Sacral pain
___ Scleroderma
___ Shoulder pain
___ Wrist, hand pain
___ Other pain ________________
____

Joint injuries or surgeries ____
____
Any other musculoskeletal problems ____
____

NEUROLOGICAL AND PSYCHOLOGICAL

___ Anxiety, panic attacks
___ Areas of numbness __________
___ Areas of weakness __________
___ Bad temper, irritability
___ Concussion
___ Considered suicide
___ Depression

___ Dizziness
___ Easily susceptible to stress
___ Fearful for no reason
___ Insomnia
___ Lack of coordination
___ Loss of balance
___ Neuropathy _____________

___ Paralysis
___ Poor concentration
___ Poor memory
___ Rages
___ Seizures
___ Stroke
___ Worry about everything

Any other neurological problems ____
____

ANY OTHER CONCERNS

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