NAME_____ **DATE**_____

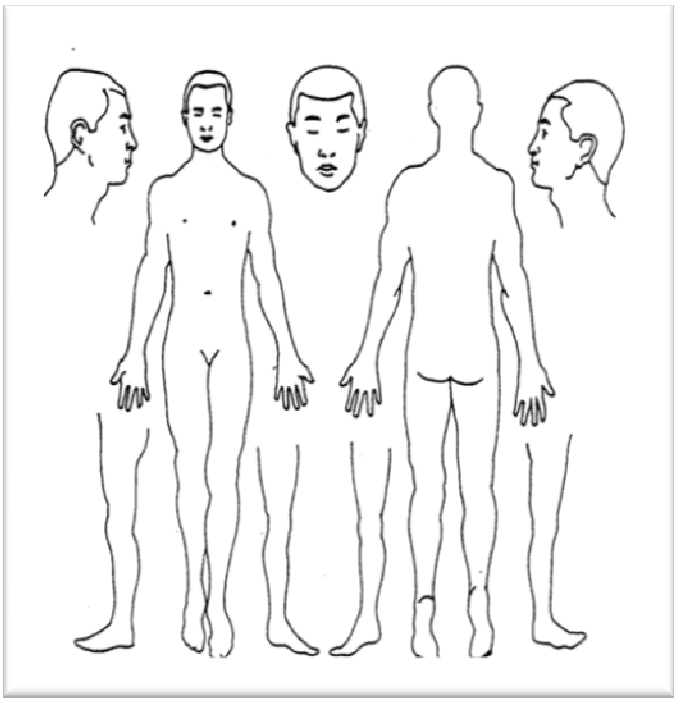
I. Goals: What would you most like to achieve through your work at Twelve Pathways Acupuncture?

1._____
2. _____
3._____
4._____
5._____

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

1._____
2._____
3._____
4._____

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/ Stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

For Women:

1. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

2. Indicate number of occurrences: Live Births _____ Pregnancies_____ Miscarriages _____ Abortions _____

3. Age: First period _____ Menopause (if applicable) _____

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____

5. Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? _____

6. Is your menses cycle regular? [ ] Yes [ ] No
   a) Average number of days of flow _____
   b) The flow is: [ ] Normal [ ] Heavy [ ] Light
   c) The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

7. Do you have the following menstruation related signs/symptoms?

[ ] Difficulty with Orgasm
[ ] Cramps
[ ] PMS
[ ] Heavy vaginal discharge between periods
[ ] Pain with Intercourse
[ ] Nausea
[ ] Bleeding between Periods
[ ] Blood Clots
[ ] Breast Distention
[ ] Vaginal Discharge

For Men:

1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe:_____

2. Check all that apply:

[ ] Erectile dysfunction
[ ] Difficulty with orgasm
[ ] Pain or swelling of the testicles
[ ] Frequent need to urinate at night
[ ] Impotence/erectile dysfunction
[ ] Premature ejaculation
[ ] Feeling of coldness or numbness in genitalia
[ ] Pain/Subtly of testicles

3. Do you get up at night to urinate? [ ] Yes [ ] No How often? _____

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

_____

5. Have you sought Medical intervention for these problems? If so, when? _____

_____

6. What treatments have you tried for these problems and how successful have they been?

_____

III. Medical History

Please add date diagnosed to all that apply:

Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	High Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

IV. Surgical History

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

V. Family History

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies (to medications, chemicals or foods):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

VIII. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet? (ie Vegetarian, Vegan, Low Carb, etc.)
_____

2. What do you eat on a "typical" day? _____
   a) Breakfast _____
   b) Lunch _____
   c) Dinner _____
   d) Snacks _____
   e) Foods you tend to crave:_____
   f) Foods you dislike: _____

IX. Social History

1. How much per day do you use of the following?
   a) Coffee, tea, soft drinks:_____
   b) Alcohol: _____
   c) Cigarettes, cigars, other tobacco: _____
   d) Other drugs:_____

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when? _____

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms? _____

7. In the past year, how many days have been significantly affected by your health? _____

8. How many days did you feel generally poor? _____

9. How many times were you in the hospital? _____

10. Please describe your current exercise regimen: Hours per week: _____ Activities: _____
_____ [ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? _____

12. Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No 13. Who would you describe as your source of primary social support? (relationship to you)

X. Other Information

Please list and briefly describe the most significant events in your life:
1._____.
2._____
3._____
4._____

Have you been treated for emotional issues? [ ] Yes [ ] No
Have you ever considered or attempted suicide? [ ] Yes [ ] No
Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:
_____
_____
_____
_____
_____

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	*Current*	*Condition*
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other:_____

SKIN & HAIR

Past	*Current*	*Condition*
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lump
[ ]	[ ]	Other:_____

EYES

Past	*Current*	*Condition*
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Cataracts
[ ]	[ ]	Sports
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Poor night vision
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Other: _____

NOSE

Past	*Current*	*Condition*
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Other:_____

BACK & NECK

Past	*Current*	*Condition*
[ ]	[ ]	Dizziness
[ ]	[ ]	Stiff neck
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Fainting
[ ]	[ ]	Other: ____

EARS

Past	*Current*	*Condition*
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other:_____

CARDIOVASCULAR

Past	*Current*	*Condition*
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other_____

THROAT & MOUTH

Past	*Current*	*Condition*
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Difficulty swallowing

RESPIRATORY

Past	*Current*	*Condition*
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other:_____

GENITO - URINARY

Past	*Current*	*Condition*
[ ]	[ ]	Kidney stones
[ ]	[ ]	Urination pain
[ ]	[ ]	Urination frequency
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other:_____

GASTRO-INTESTINAL

Past	*Current*	*Condition*
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Pain and cramps
[ ]	[ ]	Constipation
[ ]	[ ]	Rectal pain
[ ]	[ ]	Belching
[ ]	[ ]	Gas
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Blood in stools
[ ]	[ ]	Bad stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Other:_____

INFECTION SCREENING

Past	*Current*	*Condition*
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital
[ ]	[ ]	Other:_____

FEMALE

Past	*Current*	*Condition*
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain/itching of genitalia
[ ]	[ ]	Genital lesions/discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other:_____

MALE

Past	*Current*	*Condition*
[ ]	[ ]	Pain /itching genitalia
[ ]	[ ]	Genital lesions/discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other:_____

PSYCHOLOGICAL

[ ]	[ ]	Depression
[ ]	[ ]	Anxiety/stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other:_____

MUSCULAR SKELETAL

Past	*Current*	*Condition*
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm
[ ]	[ ]	Muscle twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint Pain
[ ]	[ ]	Other:_____

NEUROLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Seizures
[ ]	[ ]	Tumor
[ ]	[ ]	Pain
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Paralysis
[ ]	[ ]	Other:_____