

Welcome to Bliss Acupuncture Clinic

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you.

Bliss Acupuncture Clinic considers this information privileged physician/patient communication and will hold it in confidence.

Today's Date:

Full Name:

Date of Birth:

Age:

Sex:

Male Female

SSN:

Marital Status:

Single Married Separated Divorced Widowed

Address:

City:

State:

Zip Code:

Phone Number:

Cell Number:

E-mail:

Occupation:

Business Address:

How did you hear about Bliss Acupuncture Clinic:

Have you previously been treated with Acupuncture or Oriental Medicine: Yes No

Emergency Contact Information

Name:

Relationship:

Phone Number:

Chief Complaint/Major Health Concern:

How did this condition develop:

How long has this condition persisted:

Is there anything that makes it better:

Is there anything that makes it worse:

Have you ever been treated for this condition: Yes No

If yes, when:

where:

by whom:

What was the diagnosis:

What kind of treatment(s):

What were the results of the treatment(s):

Family Medical History

Maternal Side:

Paternal Side:

Siblings:

Birth History (prolonged labor, forceps, etc.):

Childhood Health:

Geographic location of upbringing:

Current emotional health:

Current quality of life, relationship quality:

Current predominant emotion:

Recently, have you had any unusual stress:

Stress level:

Hobbies/Recreational habits:

Do you have a regular exercise program: Yes No

If yes, describe:

Traveled abroad in the past year: Yes No

If yes, where:

Do you use coffee/tea, tobacco, or alcohol: Yes No

If yes, how much of each and for how long:

Please list any substances that you are allergic to:

Medications, herbs, vitamins, and supplements that you are currently taking:

Please list any major surgeries you have had & date:

Please list any significant traumas (auto accidents, falls, etc.):

Do you have, or have you ever had any infectious disease: Yes No

If yes, please describe:

Please check all significant illnesses that apply:

Arthritis

Asthma

Autoimmune Disease

HIV/AIDS

Cancer

Connective Tissue D/O

Diabetes

Gallstones

Heart Disease

Hepatitis

Hypertension

Kidney Stones

Rheumatic Fever

Ruptured Appendix

Seizure

Thyroid Disease

Venereal Disease

Please check any symptoms you currently have or have experienced in the past 3 months.

General Symptoms:

Chills

Fever

Allergies

Aversion to Heat

Aversion to Cold

Fatigue

Low Energy

Dizziness

Excess Thirst

Lack of Thirst

Insomnia

Nervousness

Numbness

Spontaneous Sweating

Night Sweating

Lack of Sweating

Weight Loss

Weight Gain

Peculiar Smells

Sudden Energy Drops - If yes, when

Head, Ear, Eyes, Nose & Throat Symptoms:

Headaches

Heaviness of Head

Sore Lips

Taste Changes

Teeth Problems

Earaches

Hearing Loss

Ringing in Ears

Ear Discharge

Sinus Problem

Blurred Vision

Double Vision

Tunnel Vision

Eye Pain

Red/Inflamed Eye

Cataract

Nasal Obstruction

Nasal Discharge

Nosebleeds

Loss of Sense of Smell

Phlegm in Throat

Hoarseness

Recurrent Sore Throat

Respiratory Symptoms:

Asthma

Shortness of Breath

Emphysema

Hay Fever

Persistent Cough

Coughing Blood

Phlegm Production

Recurrent Bronchitis

Difficulty Inhaling

Difficulty Exhaling

Cardiovascular Symptoms:

Chest Pain

High Blood Pressure

Low Blood Pressure

Irregular Heart Beat

Poor Circulation

Varicose Veins

Swelling of Ankles

Hypochondriac Pain

Distention in Chest/Hypochondrium

Gastrointestinal Symptoms:

Abdominal Pain

Stomachache

Bloating

Belching

Gas

Indigestion

Reflux

Poor Appetite

Difficulty Swallowing

Nausea

Vomiting

Vomiting Blood

Constipation

Diarrhea/Loose Stool

Bloody Stool

Black Stools

Hemorrhoids

Muscoskeletal Symptoms

(Check if you are or have experienced any pain, numbness, or weakness in the following):

Shoulders

Neck

Arms

Hands

Joints

Hips

Knees

Legs

Low Back Pain

Pain All Over

All Over Weakness

Hot Limbs

Cold Limbs

Lack of Strength

Broken Bones

Genitourinary Symptoms:

Frequent Urination

Profuse Urination

Urgent Urination

Poor Bladder Control

Scanty Urine

Dilute urine

Dark Urine

Cloudy Urine

Blood in Urine

Burning Urination

Pain prior to Urination

Pain during Urination

Pain after Urination

Kidney Infections

Neurological Symptoms:

Fainting/Syncope

Dizziness

Vertigo

Drowsiness

Loss of Balance

Poor Memory

Convulsions

Paralysis

Stroke/CVA/TIA

Seizures

Numbness

Dermal/Skin Symptoms:

Bags under Eyes

Dark Circles under Eyes

Lumps in Groin

Lumps Under Arms

Rashes/Hives

Bruise Easily

Blood not Clotting

Discoloration

Itching

Acne

Psoriasis

Brittle Nails

Dry Lips

Dry Mouth

Dry Hair

Dry Skin

Dry Eyes

Premature Graying

Hair Falling Out

Diet and Lifestyle Symptoms:

Vegetarian

Vegan

Healthy Diet

Raw Food Diet

High Protein/Low Fat

Eat a lot of Dairy

Eat a lot of Sweets

Artificial Sweeteners

Extreme Thirst

Thirst without desire to drink

Underweight

Normal for Height

Overweight

Emotional Symptoms:

Insomnia

Vivid Dreaming

Unclear Mind

Forgetful

Difficulty expressing emotions

Unrestrained Joy

Often sad

Cry uncontrollably

Anxiety

Irritability

Terror

Angry

Male Symptoms (Only):

Impotence

Genital pain

Genital Sores

Testicular Lump(s)

Penile Discharge

Nocturnal Emissions

Low Sexual Desire

High Sexual Desire

Female Symptoms (Only):

Contraceptives

Breast Lump(s)

Ovarian Cysts

Vaginal Discharge

Sores on Genitals

Endometriosis

Uterine Prolapse

Loss of Head Hair

Low Sexual Desire

High Sexual Desire

Early Menses

Late Menses

Irregular Menses

Pain before Menses

Pain during Menses

Pain after Menses

Bleeding between Menses

PMS

Heavy Menses

Light Menses

Amenorrhea

Clotting

Brownish

Watery, Thin & Bright Red

Normal Red

Flooding/Trickling

Stops & Starts

Menopausal

Date of Last Pap Smear:

Number of Pregnancies:

Number of Abortions:

Number of Births:

Number of Miscarriages:

Pregnant, if yes how many months:

Age of 1st Menses

Time between Menses:

Duration of Menses:

First date of last Menses: