North Florida Acupuncture

Acupuncture & Natural Medicine

4509 NW 23rd Ave, Suite 19B
Gainesville, FL 32606
352-281-8989
nflacupuncture@gmail.com

Name: _____ Date: _____

Address: _____City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Business Address: _____ City: _____ State & Zip:_____

Place of Birth: _____ Date of Birth: _____Age: _____ Height:_____ Weight: _____

Sex: _____ Male _____ Female Marital Status: (Single, Married, Life Partner, Divorced, Widowed)

Contact In Case of Emergency:

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our clinic? _____

When and where did you last receive health care? _____
_____

Do you have an reason to believe you may be pregnant? Yes No If so, how far along are you? _____

Do you have any infectious diseases? Yes No If yes, please identify the condition: _____

Has your medical case been referred to an attorney? Yes No

Please list your primary health complaints/concerns: _____
_____
_____
_____

Please list any medications (including natural remedies) you are currently taking or attach a list: _____
_____
_____
_____

List any and all previous "significant health events" in chronological order (include surgeries, traumas, illnesses):

Health Event *Ex. Concussion from bicycle accident*	**Age Occurred** *5 years old*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

General Health Assessment: Please check those symptoms that apply. Please include all symptoms or conditions that you suffer from, including those you are currently taking medications for. *Example: if you take a hypertensive drug for hypertension and even though it is controlled, please include that as one of your complaints.*

Family's Medical History Only:
(Please indicate just your family history of diseases below, not your current history)

___ Asthma
___ Allergies/Hay fever
___ Cancer
___ Degenerative conditions
___ Diabetes
___ Heart disease
___ Hepatitis
___ High Blood Pressure
___ Infectious disease
___ Kidney disease
___ Mental illness: _____
___Rheumatic Fever
___ Parkinson's disease
___ Seizures
___ Stroke
___ Thyroid disorders
___ Tuberculosis
___ Venereal disease
___Other: _____

Personal Birth & Medical History:

___ Alcohol/drugs used by mother
___ Mother and/or father exposed to toxins before conception or during pregnancy
___ Emotional or physical trauma suffered by mother during pregnancy
___ Poor nutrition by mother
___ Mother smoked/second hand
___ Prior miscarriage by mother
___ Late delivery
___ Premature delivery
___ Rapid labor by mother
___ Slow, long labor by mother
___ Induction of labor
___ High forceps
___ Breech birth
___ Cord wrapped around neck
___ Cesarian section
___ Birth weight in lbs.: _____
___ Spent time in incubator after birth
___ Jaundiced as an infant
___ Bottle-fed
___ Breastfed
___ APGAR score _____
Number of siblings: _____
Position among your siblings: _____
___ Chicken Pox
___ Diphtheria
___ Ear infections
___ Measles
___ Mumps
___ Rheumatic Fever
___ Rubella
___ Scarlet Fever
___ Tonsillitis
___ Slow or delayed development
___ Childhood obesity
___ ADD/ADHD
___ Hyperactivity
___ Learning disabilities
___ Physical, emotional, sexual abuse
___ Tubes in ears
___ Other: _____

Ears, Eyes, & Mouth Health:
___ Ear discharge
___ Ear pain
___ Ear infection history _____
___ Hearing loss
___ Ringing in the ears (tinnitus)
___ Cataracts
___ Conjunctivitis
___ Dry, itchy, watery eyes
___ Double Vision
___ Eye stress, easily fatigued
___ Floaters (spots in visual field).
Please list color and shape: _____
_____
___ Glaucoma
___ Glasses/contacts: _____
_____
___ Grit or stickiness to the eyes
___ Macular degeneration
___ Styes
___ Bleeding Gums
___ Blisters or canker sores
___ Gingivitis/gum disease
___ Other: _____

Hair, Nail, & Skin Health:
___ Brittle or dry hair
___ Dandruff
___ Hair loss (alopecia)
___ Nail fungus (hands or feet)
___ Poor nail health or other irregularities: _____
___ Acne
___ Boils
___ Body odor
___ Cancers (melanoma, basal, etc)
___ Cold sores (herpes simplex)
___ Dry skin
___ Excessive perspiration
___ Hives or rashes
___ Itching skin
___ Lipomas (fatty tissue growths)
___ Moles, recent or changes to
___ Oily skin
___ Reactions to insect bites
___ Scars (locations): _____
___ Sebaceous cysts
___ Shingles (herpes zoster)
___ Skin tags
___ Swellings, lumps, nodules
___ Warts
___ Other: _____

Respiratory Health:
___ Allergies/hay fever
___ Asthma
___ Bronchitis
___ Colds, frequent
___ Cough (acute or chronic)
___ Emphysema
___ Hoarseness
___ Laryngitis
___ Nasal congestion
___ Phlegm, excessive production
___ Pleurisy
___ Pneumonia
___ Post-nasal drip
___ Shortness of breath
___ Snoring
___ Sore throat (acute or chronic)
___ Other: _____

Blood/Cardiovascular Health:
___ Anemia
___ Aneurysm
___ Angina/heart pain
___ Blood clots
___ Blood type: A O B AB *(circle)*
Positive or Negative type *(circle)*
___ Bruise easily
___ Chest pain or tightness
___ Cold hands and feet
___ Heart attack (history of)
___ Irregular heart beat
___ Heart disease
___ High cholesterol
___ Hypertension (high BP)
___ Hypotension (low BP)
___ Mitral valve prolapse
___ Murmur
___ Palpitations
___ Stroke (history of)
___ Varicose veins
___ Other: _____

Gastrointestinal & Weight Health:
___ Abdominal pain/cramps
___ Acid reflux/heartburn
___ Anorexia or Bulimia
___ Bloating & distension
___ Chronic use of laxatives
___ Colitis
___ Crohn's Disease
___ Constipation
___ Diarrhea
___ Esophageal spasms
___ Food allergies/sensitivities
___ Gallbladder disease
___ Gas/flatulence
___ Greasy, fatty food intolerance
___ Liver Disease (cirrhosis)
___ Liver, fatty
___ Hemorrhoids
___ Hiccoughs
___ Indigestion
___ Irritable Bowel Syndrome
___ Mouth taste (circle which apply): bitter; metallic; sticky; sweet
___ Nausea and/or vomiting
___ Pancreatitis
___ Parasites (history of)
___ Rectal itching
___ Stomach or duodenal ulcers
___ Stools (please circle those that apply): bloody; tarry; clay colored; mucus in stools; undigested food
___ Weight: overweight underweight *(circle)*. How many lbs over or underweight? _____
Frequency of bowel movements per day: _____
Do your bowel movements float or sink? _____
___ Other: _____

Genito-Urinary Health:
___ Bed wetting (or history of)
___ Blood in the urine
___ Cystitis (bladder pain)
___ Dribbling after urination
___ Edema/leg swelling
___ Frequent urination
___ Incontinence
___ Kidney disease
___ Kidney stones
___ Nocturia (night-time urination)
___ Nephritis
___ Urethritis
___ Urinary tract infection history
How many times a day do you urinate? _____
What color is your urine?_____
Other: _____

Women's Reproductive History:
___ Age of 1st menses _____
___ Length of menses _____
___ Time between cycles _____
___ Heavy Bleeding
___ Light Bleeding
___ Menstrual blood color: _____
___ Clotting *(please describe the color of the clots)* _____
___ Lack of menstruation
___ Irregular menstruation
___ Painful menstruation
___ Pre-menstrual syndrome (breast tenderness, irritability, cramps, etc)
___ Bloating, water retention with period
# of abortions: _____
# of live births: _____
# of miscarriages: _____
___ Traumatic births
___ Use of birth control *(age & duration)* _____
___ Postpartum weakness
___ Difficult conception/infertility

Women's Health (if applicable):
___ Abdominal lumps or masses
___ Breast cancer
___ Breast cysts or lumps
___ Breast tenderness
___ Endometreosis
___ Estrogen replacement use

___ Fibroids
___ Hot flashes
___ Menopause, age begun
___ Menopausal symptoms
___ Menstrual odor, strong
___ Nipple discharge
___ Pelvic/genital pain
___ Positive mammogram/pap smear
___ Severe menstrual cramps
___ Painful sex
___ Sex drive low
___ Sex drive excessive, difficult to control impulses
___ Vaginal discharge
___ Vaginal dryness
___ Vaginal odor
___ Venereal disease
___ Yeast infections
___ Other: _____

Men's Health (if applicable):
___ Erectile dysfunction
___ Impotence
___ Penile discharge
___ Premature ejaculation
___ Prostate enlargement/problems
___ Seminal incontinence
___ Sex drive diminished
___ Sex drive excessive
___ Venereal disease
___ Other: _____

Endocrine Health:
___ Addison' disease
___ Cushing's syndrome
___ Diabetes Type I or II
___ Diabetes Insipidus
___ Fatigue (*time of day*): _____
_____
___ Feeling hot or cold (*circle*)
___ Hypoglycemia
___ Hypothyroid
___ Hyperthyroid (Grave's Disease)
___ Insulin resistance
___ Lethargy
___ Pituitary disorder
___ Night sweats
___ Weight gain
___ Weight loss
___ Other: _____

Neurological & Brain Health:
___ Concussion history
___ Difficulty concentrating
___ Drowsiness
___ Epilepsy
___ Lack of coordination and balance
___ Numbness & tingling in the limbs
___ Paralysis
___ Seizures
___ Tremors
___ Vertigo or dizziness
___ Other: _____

Musculo-skeletal Health & Pain:
___ Arm and elbow pain
___ Hand and wrist pain
___ Knee pain *(location)*: _____
___ Leg & calf pain
___ Gout
___ Hip pain and/or sciatica
___ Lower back pain
___ Neck, shoulder, upper back pain
___ Whole body pain
___ Facial pain/paralysis
___ Jaw tension/pain (TMJ syndrome)
___ Headaches *(location & sensation):* _____
_____
___ Migraines
___ Rheumatoid arthritis
___ Osteo-arthritis
___ Osteopenia (weakening bones)
___ Osteoporosis (bone loss)
___ Sciatica (down back of leg, side of leg, or both?) _____
___ Spinal curvature (scoliosis, lordosis, kyphosis, etc) _____
___ Tension in the back, shoulders, & neck related to stress response
___ Other: _____

Immune Health & Toxicity:
___ Candidiasis or other fungal infection history
___ Chemical sensitivities
___ Chemotherapy or radiation treatment history
___ Chronic Fatigue Syndrome
___ Chronic infections: _____
_____
___ Epstein Barr Virus
___ Hepatitis A, B, C, D, E
___ HIV/AIDS
___ Leukemia
___ Lyme disease
___ Lymph node swelling
___ Lymphoma
___ Mononucleosis
___ Parasites _____
___ Reactions to food additives
___ Recent or past exposure to toxins, chemicals, pesticides, herbicides, mold, etc in the home, work places, or living environment _____
___ Live in home older than 30 years

Environmental Adaptation:
___ Changes in weather or barometric pressure cause aggravations to symptoms or adverse reactions
___ Cold/damp environments cause aggravations to symptoms or adverse reactions
___ Cold/dry environments cause aggravations to symptoms or adverse reactions
___ Hot/humid environments cause aggravations to symptoms or adverse reactions
___ Hot/dry environments cause aggravations to symptoms or adverse reactions
___ Seasonal changes cause aggravations to symptoms or adverse reactions

Lifestyle: *(Please indicate amount)*
___ Alcohol consumption: _____
___ Caffeinated and carbonated beverages: _____
___ Coffee or black tea:
___ Exercise: _____
___ Recreational drugs _____
_____
___ Tobacco consumption _____
___ Water consumption:_____
How often do you eat? _____
Do you suffer from insomnia? _____
Is it more difficult to get to sleep, stay asleep, or both? _____
How many hours do you sleep per night?_____
If you sleep for 8 hours are you rested or still wake tired? _____

Psychological/Emotional Health:
___ Anxiety
___ Depression
___ Bi-polar
___ Schizophrenia
___ ADD or ADHD
___ Addictions
___ Attempted suicide or thoughts of
___ Panic attacks
___ PTSD
___ Other: _____

Please continue to the next page for continuation of the questionnaire which assess mental & emotional health and stressors. It is extremely important to fill the remaining portion of the questionnaire out as mental & emotional conditions are almost always associated with illness, even when the complaints seem just "physical". We thank your for your thoroughness in completing this questionnaire as it is of utmost importance in completely assessing your health concerns.

~North Florida Acupuncture

5 Element Assessment:
*Please check no more than **2** below & circle things that apply specifically.*

___ *Wood*- tend to be easily angered and suffer from resentment, bitterness, & find it difficult to forgive. Can be irrational, frustrated, impatient, always complaining. Indecisive.
___ *Fire*- tend to not show emotions & always "doing fine". Or tend to be overly emotional and elated- a joy seeker needing constant attention, interaction, and stimuli. May be emotionally vulnerable & suffer from emotional instability .
___ *Earth*- tend to obsess over things, worry, be a day dreamer, overly sympathetic towards others, and overly concerned. May suffer from loss of self esteem, despair, or distrust.
___ *Metal*- tend to suffer from grief, difficulty getting over the loss of love ones, sadness, and depression after a loss. Prone to crying. Have a rigid & fixed worldview and like things black & white.
___ *Water*- tend to be fearful, don't engage in certain things for fear of failure, feel insecure, suffer from a lack of will power and timidity.

Mental/Emotional Patterns:
Which of the following are most bothersome to you right now or characteristic of you? Circles those words or themes that most apply.

___ My need for harmony & desire to conceal my inner stress behind a cheerful face & life free of worry (Agrimony)
___ My vague fears, apprehensions, & acute anxiety (Aspen)
___ My critical, judgmental, intolerant nature & inability to see things through someone else's eyes (Beech)
___ My lack of will power, inability to say no to others, & difficulty meeting my own needs first (Centaury)
___ My inner insecurity & lack of confidence in my own judgments (Cerato)
___ My inner emotional pressure with fear of losing control, rash reactions, & sudden bursts of rage (Cherry Plum)
___ My tendency to make the same mistakes over & over and never seemingly learn from them (Chestnut Bud)
___ My possessiveness or need to manipulate, often feeling a lack of appreciation & love (Chicory)
___ My daydreaming & unrealistic nature; difficulty being aware & present of what is going on around me (Clematis)
___ My tendency to be picky about details, cleanliness , order, or my self-appearance (Crab Apple)
___ My tendency to feel overly responsible, creating a temporary sense of being overwhelmed & inadequate (Elm)
___ My negative expectations- feeling easily discouraged, doubtful, skeptical, & pessimistic (Gentian)
___ My hopelessness, resignation & feeling of "oh, what's the use" (Gorse)
___ My tendency to be too self absorbed & preoccupied by my own troubles or affair; need for an audience (Heather)
___ My anger, rage, envy, hatred, or jealousy (Holly)
___ My tendency to dwell on the past, long for days gone by, and/or not live in the present (Honeysuckle)
___ My mental weariness, & exhaustion to meet the challenges of the day ahead (Hornbeam)
___ My impatience, irritability, & quickness to react (Impatiens)
___ My lack of self esteem & feelings of inferiority that lead to expectations of failure (Larch)
___ My anxiety & fears along with shyness, timidity, & fear of the world (Mimulus)
___ My deep gloom, depression, or melancholy that can come & go out of the blue (Mustard)
___ My need to endure at any cost, struggling on never giving up even when tired (Oak)
___ My lack of energy & exhaustion on both the physical & mental levels (Olive)
___ My tendency to blame myself for the mistakes of others, feel guilty, and the need to apologize frequently (Pine)
___ My tendency to be too tied to someone emotionally (Red Chestnut)
___ My tendency to panic easily (Rock Rose)
___ My exaggerated self-discipline & self-perfection; tendency to be hard on myself and suppress my inner needs (Rock Water)
___ My indecision, changing opinions & moods from one moment to the next; feeling a lack of inner balance (Scleranthus)
___ My feelings of vulnerability, shock, & numbness or connection to an traumatic event that occurred recent or some time ago (Star of Bethlehem)
___ My despair & desperation feelings like as if I'm at my limits & things are more than I can bear (Sweet Chestnut)
___ My excessive zeal & enthusiasm which causes personal strains (Vervain)
___ My need for domination, ambition, & strive for authority (Vine)
___ My inability to be true to myself particularly in periods of major life transitions (Walnut)
___ My isolation or tendency to withdraw & be aloof around others (Water Violet)
___ My never-ending, obsessive thoughts; inability to turn off my mind (White Chestnut)
___ My lack of clear inner direction with feeling bored easily, dissatisfied, & not knowing my purpose in life (Wild Oat)
___ My apathy, lack of interest & ambition, resignation, & feeling I've given in to fate (Wild Rose)
___ My bitterness, resentment, & feelings of victim-hood (Willow)
___ My acute stress, recent emotional trauma, recent physical trauma, injury, etc. (Rescue Remedy)

Please list any other areas of concerns not covered in this questionnaire:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature:
_____

Date: _____

Practitioner Signature:
_____

Date: _____