Acupuncture South East

INITIAL CONSULTATION FORM

Date____

Name____

Address______________________________________

____

Date of Birth____________________Age__________

Registered GP surgery__________________________

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Occupation____________________________________

Phone____

Email____

Another person we may contact if needed:

Name____

Phone____

What are your treatment goals?____

Medical history: (major injuries, accidents, operations, childhood illnesses etc)

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Current medication:

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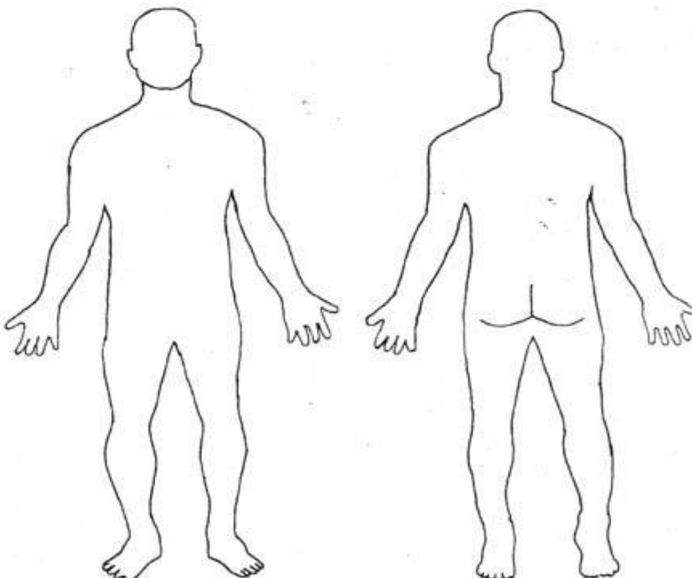
Please mark the areas of concerns/pain:



Site of pain:

When did it start:

Describe the pain/sensation: (sharp, burning, dull, ache, shooting, severe, tingling, numbness, tightness, compressed etc)

Radiating anywhere else:

Other symptoms/ treatments/imaging etc:

Worse morning/evening etc:

Anything exacerbate/ease:

Severity: /10

Life style: Smoking, alcohol & recreational drugs
(Type, amount & frequency?)

Exercise: Yes No
(Types of exercise & frequency)

Appetite: Good Bad

Diet: Describe in general what you eat, what you exclude & any cravings (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Please submit a comprehensive 3 day food diary (incl. meal times) if you consider this to be needed for your appointment

Fluid intake & types of drinks?

Energy levels: (10=the best) **/10**

Sleep: Good Bad Vivid dreams/nightmares

Problems getting to / staying asleep

Tired: Morning Afternoon Evening

Headaches/Migraines: Yes No

Location:

Duration:

Time of day:

Type of pain: Dull Sharp Throbbing Compression
Nausea/vomiting Light/smell sensitivity Auras

Frequency:

Sweat: Day Night

Body Temperature: Hot Cold Dry mouth Thirst

Digestion: Bloating Gas Nausea Pain Acid
Heart burn

Bowel movement:
Frequency:

Constipation Diarrhoea IBS

Urgent mucus smelly painful itchy incomplete undigested food

Urine:
Frequency: Very often Not much
At night: Yes No

Cystitis Thrush

Skin: Dry Greasy Itchy Red Pale Acne
Eczema Psorasis

Heart: Chest pain Palpitations Anxiety attacks

Low/High blood pressure Pacemaker Arrhythmia

Circulation: Dizziness Cold hands or feet

Breathing: Asthma Hayfever Frequent colds

Eyes: Floaters Dry Blurry Red Yellow

Mood: Depression Anger Grief Worry Mania
Anxiety

Always had or come on more recently?

WOMEN ONLY

Are you Pregnant? Yes No

How many children do you have?

Miscarriages? Yes No

Child birth:

Additional info:

Periods:
Regular Irregular

Length of cycle? (21-32 days?)

Length of bleed? (3-9 days?)

Quantity: Light Moderate Heavy Flooding

Clots: Yes No

Pain: Dull Sharp Dragging Breast tenderness Nausea

Location of pain?

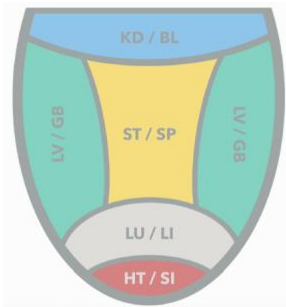
PMT? Yes No

Headaches Spots Bloating Mood swings

When does the pain / PMT occur?

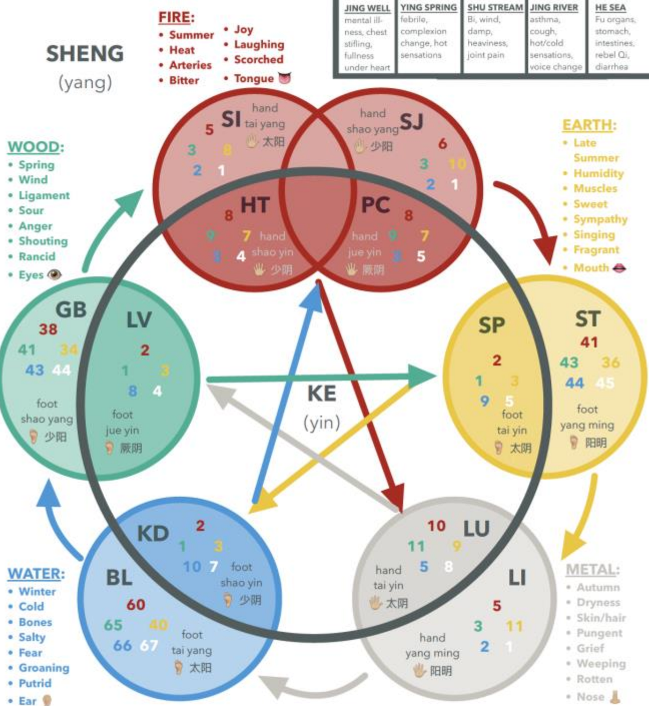
PRACTITIONER USE ONLY

Tongue:

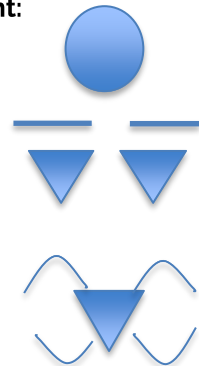


Pulse:

L/Bl		**R/Qi**
Ht/SI	**U.J.** (Ren17)	Lu/LI
Liv/GB	**M.J.**(Ren 12)	Sp/St
Kid Yin	**L.J.** (Ren 7)	Kid Yang



Postural Assessment:



	Master	Couple
Ren CV	LU7	KD6
Yin Qiao	KD6	LU7
Du GV	SI3	BL62
Yang Qiao	BL62	SI3
Chong	SP4	PC6
Yin Wei	PC6	SP4
Dai	GB41	SJ5
Yang Wei	SJ5	GB41