Zendigo Acupuncture & Holistic Health
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www.zendigoacupuncture.com

PATIENT HISTORY Todays Date:_____

This clinic specializes in acupuncture and herbal care. We ask you to fill out this form for either consultation or examination purposes.

Examinations are done routinely to determine the nature and extent of the problem. The acupuncturist will explain the level of examination necessary for your type of condition.

NAME_____
AGE_____

HEIGHT:_____ WEIGHT:_____ SEX: M F

ADDRESS _____
CITY_____ STATE_____

ZIP_____ PHONE_____
CELL_____WORK_____

E-MAIL_____ BIRTH DATE_____ _
MARITAL STATUS: Married Single Divorced Widowed

NO. OF CHILDREN_____
OCCUPATION_____

EMPLOYER_____

REFFERED BY_____

What is your primary concern? _____ _____

_____

How did this condition develop?_____

_____

When was the first time you were aware of this condition?_____

_____

Any additional concerns requiring treatment? _____

_____

Circle any health conditions that run in your family: stroke heart problems diabetes mental illness cancer high blood pressure high cholesterol other_____

List any significant past health issues, allergies, surgeries, hospitalizations and their dates:_____

_____

Have you ever been diagnosed with an infectious disease? HIV Hepatitis B Other_____

What type of service do you desire?

_____1) Temporary relief of symptoms/pain control

_____2) Eradication of tendencies causing condition

_____3) Balanced optimum health—elimination of root cause of problem, if possible

_____4) Maintenance care—regular balancing to keep in good health

Have you ever received treatment for this condition? ____Yes ____No

If so, where _____

By Whom: _____

What were the results of treatment? _____

_____

Has the condition been getting: ___ better ___ worse ___ staying the same

Has this condition affected your: ___ home life ___ work ___ social life
___ ability to exercise ___ rest ___ sleep?

In Chinese Medicine it is important to know how long a patient has experienced his/her symptoms. Therefore, if you check a box, please indicate a number (1-3) in the blank space next to the symptom to clarify frequency and severity of the symptom.

Please check all of the conditions below that apply to you:

1= condition occurs sometimes
2= condition occurs often
3= condition is of major concern

WATER ELEMENT

□ Hearing Loss ____
□ Dizziness ____
□ Lower backache ____
□ Sinus congestion ____
□ Edema ____
□ Under eye darkness ____
□ Emotional instability ____
□ Aversion to cold ____
□ Hair thinning or loss ____
□ Premature aging ____
□ Frequent urination ____
□ Kidney stones ____
□ Perspire very easily ____
□ Weak legs/knees ____
□ Asthmatic cough ____
□ Rapid weight change ____
□ Loose teeth ____
□ Reduced sex drive ____
□ Thyroid problems ____
□ Diabetes ____

WOOD ELEMENT

- □ Headaches____
- □ Migraines____
- □ Ringing in ears____
- □ Poor eyesight____
- □ Dry eyes____
- □ Eczema____
- □ Shingles____
- □ Herpes simplex____
- □ Warts____
- □ Nervousness____
- □ Convulsion, spasms____
- □ Irritability____
- □ Hemorrhoids____
- □ Hepatitis____
- □ Ulcer____
- □ Vomiting____
- □ Gallstones____
- □ Indecisive____
- □ Fullness below ribs____
- □ Shoulder/neck tension___
- □ Insomnia____

FIRE ELEMENT

- □ Dry scalp____
- □ Skin eruptions, rashes____
- □ Cysts, tumors____
- □ Ear infections____
- □ Sore throat, tonsillitis____
- □ Lymphatic swelling____
- □ Hot palms & soles____
- □ Heart palpitations____
- □ Aversion to heat____
- □ Bitter taste in mouth____
- □ Gum problems____
- □ Nose bleed____
- □ Facial redness____
- □ Itching/burning skin____
- □ Hot hands/feet____
- □ Thirst____
- □ Vivid dreaming____
- □ Dark urine____
- □ Night sweats____
- □ Tongue sores____

EARTH ELEMENT

- □ Indigestion____
- □ Flatulence____
- □ Food Allergy____
- □ Stomach ache/ulcer____
- □ Diarrhea____
- □ Anemia____
- □ Bad breath____
- □ Mouth Sores____
- □ Heartburn____
- □ Strong appetite____
- □ Weak appetite____
- □ Nausea____
- □ Abdominal bloating____
- □ Low body weight____

METAL ELEMENT

- □ Bronchitis____
- □ Asthma____
- □ Shallow breathing____
- □ Cough____
- □ Sinus congestion____
- □ Nasal infections____

OTHER

- □ Fatigue____
- □ Arthralgia____
- □ Sciatica/nerve pain____
- □ Cold hands/feet____
- □ Tendonitis____
- □ Bursitis____

Please log your current medications:

Medication	Dosage	Date Prescribed	Reason

PAIN & COMMENTS (to be filled out by patient) Please also fill out Pain form if Pain is your main complaint.

_____

_____

_____

_____

_____

_____

_____

Practitioner notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(for practitioner use only)