Thank you for taking the time to fill this out carefully. Though some questions might seem irrelevant to your condition, every piece of information helps to form a complete diagnosis. Oriental medicine treats the whole person, not just disease.
All information will be confidential. If you have any questions, please ask.

NAP 3823 Airport Blvd. Suite C, Austin TX 78722 Tel: (512) 473-8884 E-mail: contact@napaustin.org www.napaustin.org

Name______________________________ Gender__________ Date____________________

Date of Birth_________________ Age____________ Occupation_________________________ Marital Status_________________

(H) Phone___________________________ (W) Phone___________________________ (M) Phone_____________________________

Address: Street____

City__________________________State___________Zip________________E-mail____

Emergency contact____ Relationship & phone __________________________________

Family physician or chiropractor____

Have you had acupuncture and/or Chinese herbs before?____

How did you hear about NAP?____

Main complaint ____

How long have you had this problem?_________________What seems to cause this problem?_________________________________

Have you been given a diagnosis? If so, what?____

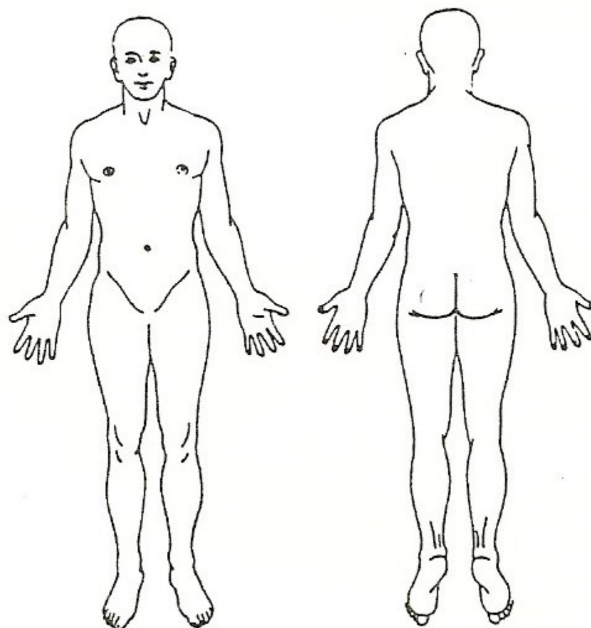
To what extent does this problem interfere with your daily activities? ____

What kinds of treatment have you tried?____

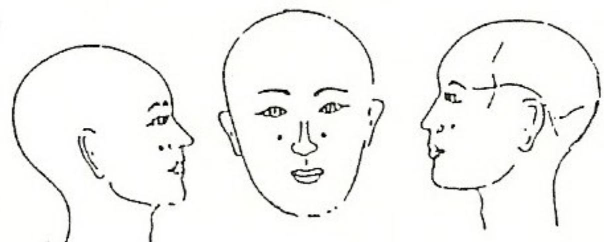
What makes it better?_______________________________________ Worse? ____

Please rate your current pain or discomfort on a scale of 1 – 10: Very slight 1 2 3 4 5 6 7 8 9 10 Unbearable

Is there anyone in your family with the same/similar problems?____



Please indicate painful or distressed areas



Medical History (please circle if you have had a diagnosis of any of following and include dates)

Cancer Diabetes Hepatitis Thyroid Disease Seizures Anemia

HIV/AIDS Arthritis Tuberculosis Hypertension Emotional Imbalance Alcohol/drug addiction

Heart Disease Digestive Disorders Fibromyalgia Venereal Disease Breathing problems

Other____

Surgeries/Hospitalization ____

Allergies____

Medications, vitamins, herbs taken within the last 3 months (Please include reasons and known side effects)

____

____

____

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____

____

Please describe your childhood health____

____

Please describe family medical history____

____

Recent medical tests

○ Physical ○Cholesterol ○Blood test ○ Prostate exam ○HIV ○STD

○ Pap smear ○ Mammogram ○Thyroid ○ Other_____________________

Test results and date____

Occupation

Do you usually work ○ indoors ○ Outdoors ?

Occupational stress (chemical. physical, psychological, etc.) ____

Personal

Height________________ Weight now________________ One year ago ___________________________

Maximum weight_________________________ @ Year_____________________ Blood type ____________________________

Daily Routines

Do you smoke? ◯ Yes ◯ No What?__________________ How many per day?__________

Since when?___________________________ Recreational drugs? ____

How many hours do you sleep in general?_____________________________ When do you usually go to bed?__________________

Do you exercise regularly? ◯ Yes ◯ No What kind of exercise?____

What are your hobbies/ things you most enjoy doing?____

____

Diet

How much coffee do you drink? _______cups/day; Colas________/day; Tea________/day ; Water__________/day

What kind of alcoholic beverages do you usually drink?___________________ Average # of drinks/week_________________

Are you a vegetarian? ◯ Yes ◯ No ◯ Yes, but not strict Do you eat a lot of spicy food? ◯ Yes ◯ No

What kind of food cravings do you have?____

What is your opinion of your average daily diet?____

Signs & Symptoms

Please check any of the following that applies to you now or in the past 6 months.

General

◯Poor appetite ◯Poor sleeping ◯Fatigue ◯Fever ◯Chills

◯Night Sweats ◯Sweat easily ◯Tremors ◯Cravings ◯Change in appetite

◯Poor balance ◯Bleed easily ◯Bruise easily ◯Localized weakness ◯Weight loss/gain

◯Peculiar tastes ◯Desire hot food ◯Desire cold food ◯Strong thirst (cold or hot drinks)

◯Sudden energy drop (What time of day)_______________ Favorite time of year_______________ Worst time of year___________

____

Skin & Hair

◯Rashes ◯Ulcerations ◯Hives ◯Itching ◯Eczema

◯Pimples ◯Dandruff ◯Dry skin ◯Recent moles ◯Loss of hair ◯Purpura

◯Change in hair or skin texture ◯Other?

____

Musculoskeletal

◯Joint disorders ◯Muscle weakness ◯Muscle pain/soreness ◯Tremors

◯Difficult walking ◯Cold hands/feet ◯Swelling of hands/feet ◯Back pain ◯Scoliosis

◯Hernia ◯Numbness ◯Tingling ◯Paralysis ◯Neck tightness/pain

◯Shoulder pain ◯Hand/wrist pain ◯Hip pain ◯Knee pain ◯Joint sprain ◯Other

____

Head, Eyes, Ears, Nose, Throat

◯Dizziness ◯Migraines ◯Concussion

◯Eye strain ◯Eye pain ◯Color blindness ◯Night blindness ◯Poor vision ◯Cataracts

◯Blurry vision ◯Earaches ◯Ringing in ears ◯ Poor hearing ◯Spots/floater in vision

◯Sinus problems ◯Nose bleeding ◯ Sore throat ◯Grinding teeth ◯Teeth problems ◯Facial pain

◯Jaw clicks/TMJ ◯Sores on lips/tongue ◯Difficulty swallowing ◯Other

Cardiovascular ◯High Blood Pressure ◯Low Blood Pressure ◯Chest pain ◯Palpitations

◯Fainting ◯Phlebitis ◯Irregular heartbeat ◯Rapid heartbeat ◯Varicose veins ◯Other

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Respiratory ◯Cough ◯Coughing blood ◯Wheezing ◯Difficulty in breathing

◯Bronchitis ◯Pneumonia ◯Chest pain ◯Production of phlegm ◯Other

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Gastrointestinal ◯Nausea ◯Vomiting ◯Diarrhea ◯Constipation ◯Gas

◯Belching ◯Black stools ◯Blood in stools ◯Indigestion ◯Bad breath ◯Rectal pain

◯Hemorrhoids ◯Abdominal pain/cramps ◯Parasites ◯Chronic laxative use

◯Gallbladder problems

Neuro-psychological ◯Loss of balance ◯Lack of coordination ◯Concussion

◯Depression ◯Anxiety ◯Stress ◯Bad temper ◯Bi-polar

Genito-Urinary ◯Pain on urination ◯Frequent Urination ◯Blood in urine ◯Urgency to urinate

◯Kidney stones ◯Unable to hold urine ◯Dribbling ◯Pause of flow ◯Frequent urinary tract infection

◯Pain in genitals ◯Itching in genitals ◯Other

Female ◯Frequent vaginal infections ◯Pelvic infection ◯Endometriosis ◯Vaginal discharge

◯Fibroids ◯Ovarian cysts ◯Irregular periods ◯Clots ◯Pain/cramps prior/during periods

◯Breast tenderness ◯Breast lumps ◯Fertility problems ◯Hot flashes ◯Moodiness related to periods

_______# pregnancies ________# births _________ # miscarriages ________ # abortions

_______ # premature births _______ # cesareans _________ # difficult delivery

Menstrual flow: ◯Heavy ◯Light ◯Clots ◯Painful ◯spotting between periods Color of menses______________________

Length of period________________ Date of last period________________ Days in cycle____

Age of first menses_____________Date of last PAP______________ PAP results____

PMS symptoms____

Do you practice birth control? ◯ Yes ◯ No If yes, what type and for how long?____

Is there any possibility that you are pregnant? ◯ Yes ◯ No

Perimenopause: ◯skipped/irregular periods ◯Hot flashes ◯Moodiness ◯Vaginal dryness

Menopause age__________ Hysterectomy/age and reason ________________________ HRT_________________________________

Male ◯Prostate problems ◯Discharge ◯Impotence ◯Frequent seminal emission

◯Fertility problems ◯Ejaculation problems ◯Painful/swollen testicles ◯Other

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Other health concerns: ____

____