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Medical History

Confidential

Name Sex M F Age: Today's Date:
Address: City: Zip:
Home Phone: Business Phone:
Birth date:
Social Security:
Occupation: Referred by:

Have you ever had acupuncture before? Yes/No Are you pregnant? Yes/No
Have you tested positive for the HIV virus? Yes/No Do you have any surgical implants? Yes/No

Who is your Western Family Doctor? Gynecologist
In case of emergency, call... Telephone

Chief Complaint:

When did it start/ date of onset?
How did it develop?
Have you had this in the past?
What makes it better?
What makes it worse?
Is your condition: ___Getting worse ___Constant ___Comes and goes
What treatments have you already received?
If yes, when
What were the results of your past treatments?

Drug, Food or Supplement Allergies

Four horizontal lines for listing allergies.

Table with 3 columns: Medication or Supplement you are currently taking, Dosage, Date Started. Includes three rows of horizontal lines for data entry.

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Name: _____ Date: _____

Surgeries	When	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations	When	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____

How often have you taken antibiotics

	Less than 5 times	More than 5 times
Infancy/childhood	_____	_____
Teen	_____	_____
Adult	_____	_____

If your complaint is pain related, please answer the questions below:

Rate the following on a scale of 1 to 10 (0 being no pain and 10 being the most intense pain imaginable):

The pain intensity you are having at this very moment _____

The usual pain intensity you have experienced over the last week _____

How much has your pain interfered with daily activities _____

Rate how often your pain occurs:

Frequency	Duration
<input type="checkbox"/> Continuous	<input type="checkbox"/> Seconds
<input type="checkbox"/> Several Times a Day	<input type="checkbox"/> Minutes
<input type="checkbox"/> Once per Day	<input type="checkbox"/> Hours
<input type="checkbox"/> Three times a week	<input type="checkbox"/> Days
<input type="checkbox"/> Once per week	<input type="checkbox"/> Continuous

Description of pain (check any that may apply)...

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Gnawing | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Cold |
| <input type="checkbox"/> Dull | |

Name: _____ Date: _____

Please check any symptoms you currently have or have had in the past

General

- Aversion to cold
- Allergies
- Chills
- Dizziness
- Strong thirst
- Fevers
- Insomnia
- Change in Appetite
- Night sweats
- Lack of sweating
- Weight loss
- Weight gain
- Nervousness
- Other _____

Head and neck

- Blurred vision
- Heaviness in head
- Frequent headaches
- Migraine
- Earache
- Eye strain
- Nasal discharge
- Hearing loss
- Frequent sore throat
- Red eyes
- Sores on lips
- Sores in mouth
- Teeth Problems
- Neck stiffness
- Enlarged lymph glands
- Grinding teeth
- Other _____

Respiratory

- Asthma
- Allergies
- Bronchitis
- Pneumonia
- Cough
- Coughing blood
- Shortness of breath
- Phlegm production
- Difficulty inhaling
- Difficulty exhaling
- Other _____

Weight

- Under weight
- Normal weight
- Over weight
- Very overweight

Cardiovascular

- Chest Pain
- Palpatations
- Irregular Heart Beat
- Pacemaker
- High Blood Pressure
- Low Blood Pressure

Diet & lifestyle

- Vegetarian
- Whole foods diet
- Eggs in diet
- Diet high in meat
- Diet high in packaged food
- Diet high in fried food
- Eats a lot of sweets
- Smokes cigarettes
- Drinks alcohol regularly
- Regular use of caffeine
- Uses drugs
- Takes sleep aid
- Exercises regularly
- Exercises excessively

Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Strong smelling gas
- Constipation
- Diarrhea/loose stools
- Poor appetite
- Stomachache
- Bloody stools
- Black stools
- Hemorrhoids
- Nausea
- Vomiting
- Heartburn/reflux
- Other _____

Musculoskeletal -

Pain, weakness, numbness in:

- Arms
- Feet
- Hands
- Legs
- Upper back
- Mid back
- Lower back
- Neck
- Pain in joints
- Cold limbs
- Lack of strength

Neurological

- Tremors
- Seizures
- Convulsions
- Paralysis
- Recent Clumsiness
- Other _____

Emotional

- Depression
- Anxiety
- Insomnia
- Irritability
- Crying frequently
- Fearful
- Cloudy thinking
- Other _____

Genitourinary

- Dark Urine
- Diluted/Clear Urine
- Profuse Urine
- Scanty Urine
- Blood in Urine
- Cloudy Urine
- Urgency
- Pain with Urination
- Frequent Urination
- Poor Bladder Control
- Other _____