



*Lauren Buckley Acupuncture*  
 acupuncture and traditional chinese medicine

//////////////////// Personal and Confidential Information //////////////////////

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_  
 EMAIL \_\_\_\_\_ Occupation \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Allergies \_\_\_\_\_

Who should we thank for referring you to this office? \_\_\_\_\_  
 When was your last acupuncture visit? \_\_\_\_\_ With whom? \_\_\_\_\_

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer				Diabetes			
Hepatitis				Heart Disease			
Emotional Disorders				Infectious Disease			
High Blood Pressure				Seizures			

Please Circle any of the following you may have:  
 Gonorrhea/ Syphilis/ AIDS/ Herpes/ HPV/ Chlamydia. When contracted? \_\_\_\_\_

Please list the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffee				Tobacco				Water			
Drugs				Alcohol				Soda			

Please list any medications or supplements you are taking (continue on back...)

Medicine	Dosage	Reason	How long	Physician	Date of last visit

What is the MAIN REASON for your visit today? \_\_\_\_\_

Onset? \_\_\_\_\_ Other therapies? \_\_\_\_\_

Other health problems? \_\_\_\_\_

Food Cravings? \_\_\_\_\_

Date of any accidents, surgeries, hospitalizations \_\_\_\_\_

//////////////////////////////////For Women//////////////////////////////////

Are you Pregnant? \_\_\_\_\_ # of Pregnancies \_\_\_\_\_

# of live births \_\_\_\_\_ # of abortions \_\_\_\_\_ # of miscarriages \_\_\_\_\_

Age of menarche \_\_\_\_\_ Age of menopause \_\_\_\_\_

# of days in cycle \_\_\_\_\_ # of days of blood flow \_\_\_\_\_

Amount of blood flow? Excess \_\_ Moderate \_\_ Slight \_\_

Color of flow? Fresh red \_\_ Dark red \_\_ Pale red \_\_ Purple \_\_ Brown \_\_

Clots? \_\_\_\_\_ Clot size \_\_\_\_\_

Pain with period? Before \_\_ During \_\_ After \_\_

Nature of pain? Sharp/ Stabbing/ Burning/ Dull / Bloated/ Constant/ Intermittant

Location of pain? \_\_\_\_\_ (low ab, low back, thighs...)

Symptoms related to your cycle (Circle):

Yeast infections/ Vaginal Dryness/ Nausea/ Swollen Breasts/ Appetite Change/ Mood Swings/ Hot Flashes/ Night Sweats/ Libido Changes/ Headache/ Diarrhea/ Constipation/ Insomnia/ Dizziness/ Other

Have you been diagnosed with (Circle):

Fibroids/ Fibrocystic Breasts/ Endometriosis/ Ovarian Cysts/ PID

Results and Dates of last:

PAP Smear \_\_\_\_\_ Bone Density Scan \_\_\_\_\_ Mammogram \_\_\_\_\_

////////////////////////////////// For Men //////////////////////////////////

Frequency of Urination: Daytime \_\_\_\_\_ Nighttime \_\_\_\_\_

Date of last prostate exam \_\_\_\_\_ results \_\_\_\_\_ PSA results \_\_\_\_\_

Do you experience any of the following symptoms related to the prostate:

Groin pain/ rectal dysfunction/ back pain/ delayed stream/ dribbling/ incontinence/ urine retention/ libido change/ premature ejaculation/ impotence/ testicular pain/ Other

////////////////////Symptom Survey //////////////////////

Please indicate if you experience sometimes (√) or frequently (+)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> lack of appetite             | <input type="checkbox"/> knee pain                  | <input type="checkbox"/> intolerance to weather changes                     |
| <input type="checkbox"/> excessive appetite           | <input type="checkbox"/> ear ringing                | <input type="checkbox"/> aversion to cold                                   |
| <input type="checkbox"/> soft stool                   | <input type="checkbox"/> hearing impaired           | <input type="checkbox"/> aversion to hot                                    |
| <input type="checkbox"/> diarrhea                     | <input type="checkbox"/> kidney stones              | <input type="checkbox"/> allergies  |
| <input type="checkbox"/> constipation                 | <input type="checkbox"/> urinary pain               | <input type="checkbox"/> hay fever  |
| <input type="checkbox"/> # of bowel movements per day | <input type="checkbox"/> decreased sex drive        | <input type="checkbox"/> high cholesterol                                   |
| <input type="checkbox"/> flatulent/bloated            | <input type="checkbox"/> hair loss                  | <input type="checkbox"/> sudden weight loss                                 |
| <input type="checkbox"/> nausea                       | <input type="checkbox"/> hotflashes/<br>nightsweats | ////////////////////////////////////  |
| <input type="checkbox"/> vomiting                     | <input type="checkbox"/> cold hands/feet            | <input type="checkbox"/> cough  |
| <input type="checkbox"/> burping                      | ////////////////////////////////////                | <input type="checkbox"/> shortness of breath                                |
| <input type="checkbox"/> heartburn/ reflux            | <input type="checkbox"/> dry/crusty eyes            | <input type="checkbox"/> decreased sense of smell                           |
| <input type="checkbox"/> food retention               | <input type="checkbox"/> night blindness            | <input type="checkbox"/> nasal problems                                     |
| <input type="checkbox"/> obsessive thoughts           | <input type="checkbox"/> brittle nails              | <input type="checkbox"/> bronchitis   |
| <input type="checkbox"/> anxiety                      | <input type="checkbox"/> irritability               | <input type="checkbox"/> colitis/ diverticulitis                            |
| <input type="checkbox"/> abdominal pain               | <input type="checkbox"/> mood swings                | <input type="checkbox"/> hemorrhoids  |
| <input type="checkbox"/> fatigue after meals          | <input type="checkbox"/> muscle twitches            | <input type="checkbox"/> recent use of antibiotics                          |
| <input type="checkbox"/> edema                        | <input type="checkbox"/> headache/migraines         | <input type="checkbox"/> asthma   |
| ////////////////////////////////////                  | <input type="checkbox"/> genital discomfort         | <input type="checkbox"/> skin rashes  |
| <input type="checkbox"/> difficulty falling asleep    | <input type="checkbox"/> jaundice                   | <input type="checkbox"/> eczema   |
| <input type="checkbox"/> depression                   | <input type="checkbox"/> gall stones                | <input type="checkbox"/> thirst   |
| <input type="checkbox"/> nightmares                   | <input type="checkbox"/> light colored stool        | <input type="checkbox"/> no thirst  |
| <input type="checkbox"/> awaken frequently            | <input type="checkbox"/> fatigue/low energy         | <input type="checkbox"/> tmj/ jaw problems                                  |
| <input type="checkbox"/> mentally restless            | <input type="checkbox"/> blood in stool             | <input type="checkbox"/> dizziness  |
| <input type="checkbox"/> heart palpitations           | <input type="checkbox"/> black tarry stool          | <input type="checkbox"/> history of psychological, physical or sexual abuse |
| <input type="checkbox"/> heart palpitations           | <input type="checkbox"/> easily bruised             |   |
| <input type="checkbox"/> angina pains                 | <input type="checkbox"/> dizziness                  |   |
| <input type="checkbox"/> chest pains                  | <input type="checkbox"/> vertigo                    |   |
| <input type="checkbox"/> claustrophobia               | <input type="checkbox"/> asthma                     |   |
| <input type="checkbox"/> low back pain                | <input type="checkbox"/> frequent colds             |   |

Please rate how you FEEL about these areas in your life:

	Great	Good	Fair	Poor	Bad	Comments
Partner						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spirituality						