平衡

JENNIFER ROOT, L.Ac.

醫學

Licensed Acupuncturist & Traditional Chinese Medicine Practitioner

(p) 831.334.2158 (f) 831.536.7851 acupuncture@jenniferrootlac.com

Patient Name: **Date:**

MEDICATIONS & SUPPLEMENTS

Please any current prescribed, over-the-counter and/or dietary supplement or herbs taken (attach a separate sheet if necessary):

Medication / Supplement / Herb:	Dosage / How Often:	Prescribing Physician / Reason for Taking:

RECENT HEALTH HISTORY & REVIEW OF SYSTEMS

Please check any symptoms or activity you CURRENTLY experience or have experienced recently (in the last 6 months):

General, Constitutional & Psychosocial:

□ Anxiety □ Depression □ Dizziness □ Emotional Symptoms Worse at Night □ Indecisiveness □ Irritability □ Nightmares □ Panic Attack □ PTSD

□ Restlessness □ Fatigue □ Fever □ Headache □ Insomnia □ Night Sweats □ Frequent Sweat □ Memory Loss □ Weight Loss □ Weight Gain

Cardiovascular & Pulmonary:

□ Angina □ Asthma □ Bronchitis □ Bruise Easily □ Chest Pain □ Cough □ High Cholesterol □ Irregular Heartbeat □ Leg Cramps □ Palpitations □ Pneumonia

□ Shortness of Breath □ Frequent Sighing or Yawning □ Snoring or Sleep Apnea □Swelling *(legs, ankles, feet, hands)* □ Varicose Veins □ Wheezing

Head, Eyes, Ears, Nose & Throat (HEENT):

□ Changes in Vision □ Corrective Lenses □ Diminished Hearing □ Double Vision □ Dry Mouth □ Dry Eyes □ Ear Ache □ Eye Twitch □ Frequent Colds

□ Hairloss □ Itchy Eyes □ Loss of Smell □ Light Sensitivity □ Noise Sensitivity □ Nosebleed □ Red or Burning Eyes □ Ringing / Tinnitus □ Runny Nose

□ Sinus Infection □ Sore Throat □ Vertigo □ Watery Eyes

Gastrointestinal:

□ Abdominal Pain □ Acid Reflux □ Black/Tarry Stool □ Bloating □ Bitter Taste □ Constipation □ Diarrhea □ Excess Hunger or Thirst □ Gas □ Hemorrhoids

□ Indigestion □ Jaundice □ Loss of Taste □ Low Appetite □ Nausea □ Trouble Swallowing □ Ulcer □ Undigested Food in Stool □ Urgent Stool □ Vomiting

Musculoskeletal & Neurologic:

□ Arthritis □ Bone Pain □ Bone Spur □ Bunion □ Joint Pain □ Concussion □ Fainting or Lightheaded □ Fibromyalgia □ Gout □ Limited Range of Motion

□ Muscle Pain □ Muscle Weakness □ Nerve Pain □ Numbness or Tingling □ Paralysis □ Poor Balance □ Seizures □ Stiffness □ Tics □ Tremors

Skin & Lymphatic:

□ Acne □ Cysts □ Change in Moles or Growths □ Dry Skin / Hair □ Eczema □ Hives □ Itching □ Lumps □ New Moles or Growths □ Psoriasis □ Rashes

□ Sensitive Skin □ Swelling □ Swollen Lymph Nodes □ Tender Lymph Nodes

Urinary & Reproductive:

□ Blood in Urine □ Burning or Painful Urination □ Change in Urinary Frequency □ Difficult or Hesitant Urination □ Hernia □ Nocturnal Urination □ Urinary Urgency

□ Amenorrhea □ Breast Pain □ Discharge □ Dysmenorrhea / Painful Menses □ Erectile Dysfunction □ Heavy Menstruation □ High Libido □ Low Libido

□ Infertility □ Irregular Menses □ Menopause Age:_____ □ Miscarriage □ PCOS □ PMS □ Prostate Issues □ Spotting □ STD

Habits & Cravings

□ Cigarette Smoking □ Alcohol _____ drinks per week □ Recreational Drugs □ Caffiene □ Sugar □ Soft Drinks □ Salt □ Fried or Fast Food □ Other:_____

□ Preference for cold food / drink □ Preference for warm food / drink □ Thirsty with no desire to drink □ Hungry with no desire to eat □ Hungry or thirsty at night

Dietary Habits:

List any dietary restrictions (vegetarian, vegan, gluten free, dairy free, etc…):

Describe your typical breakfast:

Describe your typical lunch:

Describe your typical dinner:

Describe your typical snacks and/or desserts:

Is there anything else you would like me to know about your health history?

The above information regarding my medical history is, to the best of my knowledge, complete and accurate. I agree to promptly notify Jennifer Root, L.Ac., of any changes in my health status and/or additional medical history.

Patient Name (please print): Patient Signature: Date:

Guardian or Inturpreter's Signature: Date:

Reveiwed by: Date: