# Acupuncture Pain Clinic

Please mark C for Current or P for Past symptoms:

**Lung/Large Intestine**
___Bloody Cough
___Dry Cough
___Chronic Cough
___Cough with Sputum, Color_____
___Nasal Discharge (White / Yellow / Green) (circle which)
___Post Nasal Drip
___Sinus Infection / Congestion
___Ear Plugged / Ache
___Itchy, Red, or Painful Throat
___Recurrent Sore Throat
___Dry Mouth / Nose / Throat
___Skin Rashes / Hives / Exema
___Snoring
___Shortness of Breath
___Difficulty Breathing
___Pain With Breathing
___Allergies / Asthma
___Low Immunity
___Catch Colds Easily
___Bronchitis
___Pneumonia
___Other Lung Problems_____
___Black or Bloody Stools(circle which)
___Constipation
___IBS
___Diarrhea
___Colitis / Spastic Colon
___Rectal Pain
___Chronic Laxative Use
___Bowel Movements Per Day
___Do you crave: Pungent / Spicy
___Grief / Sadness

**Spleen/Stomach**
___Body Heaviness
___Hard to get up in Morning
___Muscles Often Feel Tired
___Energy Level: 1-10 (low to high)
___Edema (Hands/Feet)
___Easily Bruising / Bleeding
___Bad Breath
___Sweetish Taste in Mouth
___Lack of Taste
___Excess or Low Appetite (circle which)
___Excess or Lack of Thirst (circle which)
___Nausea / Vomiting
___Gas
___Belching
___Hemorrhoids
___Organ Prolapse (i.e. uterus)
___Chronic Loose Stools
___Abdominal Pain / Cramps
___Indigestion
___Heartburn
___Brain Foggy
___Mouth Ulcers
___Tendency to Gain Weight
___Do you crave: Sweet
___Over-thinking / Worry
___Other Stomach or Intestinal Problems
_____

**Heart/Small Intestine**
___Heart Palpitations
___Rapid or Irregular Heartbeat
___Chest Pain
___High Blood Pressure
___Low Blood Pressure
___Insomnia / Sleep Problems
___Vivid Dreams / Nightmares
___Easily Startled
___Dark Urine
___Red Complexion
___Do you crave: Bitter
___Anxiety / Nervous or Restless

**Liver/Gallbladder**
___Depression / Stress
___Headaches / Migraines Where and When _____
___Red / Dry / Itchy / Painful Eyes(circle which)
___Visual Problems / Blurred Vision
___Floaters
___Dizziness
___Gall Stones
___Feeling of Lump in Throat
___Clenching Teeth at Night
___Grinding Teeth
___Muscle Cramping / Twitching
___Neck/Shoulder Pain / Tightness
___Seizures/Tremors
___Poor Circulation
___Cold Hand and Feet
___Fainting
___Soft/Brittle Nails
___Bitter Taste in Mouth
___PMS/Menstrual Problems
___Breast Tenderness
___Tendonitis
___Pain Below Ribcage
___Do you crave: Sour
___Tend to be Irritable / Angry / Bad Temper
___Mood Swings

**Men only**:
___Swollen testes
___Feeling coldness or numbness in genitalia
___Testicular pain
___Other _____

**Kidney/Urinary Bladder**
___Trips To Urinate At Night
___Bladder Infection
___Incontinence
___Painful Urination
___Urgency To Urinate
___Frequent Urination
___Unable To Hold Urine
___Blood In Urine
___Color Of Urine_____
___Decrease In Flow
___Kidney Stones
___Sores On Genitals
___Weakness / Pain in Low Back
___Osteoporosis
___Feel Cold or Hot Easily (circle which)
___Low or Excess Sex Drive (circle which)
___Dark Circles under Eyes
___Thyroid Problems _____
___Poor Memory
___Hair Loss / Grey Hair(circle which)
___Hearing Problems / Tinnitus
___Cavities
___Impotence or Premature Ejaculation
___Do you crave: Salt
___Fear
___Other Kidney Or Bladder Problems _____

**Temperature**
___Fevers
___Chills
___Itchy
___Sweat Easily
___Thirsty
___Hot Palms, Bottoms Of Feet(circle which)
___Night sweats

**Blood**
___Blood Clots
___Phlebitis
___Skin Dry / Oily (circle which)
___Hair Dry / Oily (circle which)
___Loss Of Hair
___Dandruff
___Pimples
___Other Heart Or Blood Vessel Problems _____

**Musculoskeletal**
___Facial Pain
___Jaw Pain / Clicks
___Neck pain
___Shoulder pain
___Hand/wrist pains
___Back pain, Hip pain, Sciatica(circle which)
___Knee pain
___Foot/ankle pains
___Muscle pains / weakness(circle which)
___Areas of numbness, where?_____
___Other:_____

**Gynecological:**
Regular menstrual cycle Yes _____ No____
Number of children _____
Number of pregnancies: _____
Age of first menstruation: _____
Average number of days of flow: _____
How many days between periods:_____
Vaginal discharge Yes _____ No_____ if yes what color (clear, brown, red or _____)
Pregnant Yes _____ No _____
How Many Months____
Age of menopause (if applicable): _____
Bleeding between periods: Yes___ No ___
___Painful periods
___Breast lumps
Last pap _____
Do you practice birth control?Yes ___ No___
What type and for how long?
_____

**Neuropsychological:**
___Seizures
___Concussion
___Lack of coordination
___Poor balance
___Poor Memory
___Tremors
___Other Neuropsychological problems
_____

**Do you experience any of the following premenstrual syndromes?**
___Nausea
___Vomiting
___Food Cravings
___Depression
___Headaches /Migraines
___Water retention
___Irritability/mood swing
___Anxiety
___Other emotions? _____
___Sharp pain, where? _____
___Dull pain, where? _____
___Breast swelling/Breast tenderness
___Vaginal discharge
___Changes in body/psyche prior to menses
___Vaginal sores

**Please complete the following menstrual chart:**

| Circle one of description | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Color (normal, bright, red, pale, brown rust, dark, purple, other) | | | | | | | |
| Amount of flow (normal, heavy, light) | | | | | | | |
| Cramps (location, dull, sharp, other) | | | | | | | |
| Clots(large, small, black, purple, red, other) | | | | | | | |
| Nausea (check, if yes) | | | | | | | |
| Other | | | | | | | |