Patient Information

CONFIDENTIAL

ACURA Acupuncture Clinic ■ Park Axis Shibuya 702, 1-4-7 Shibuya, Shibuya-ku ■ Tokyo 150-0002 Phone: 03-5469-0810
www.acuraclinic.com

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Clinic considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST)	DATE

AGE	DATE OF BIRTH	SEX	MARITAL STATUS
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PHONE	EMAIL ADDRESS

HOME ADDRESS		
CITY		ZIP

OCCUPATION	CELL PHONE

EMPLOYED BY	
REFERRED BY (Please write full name of referrer if possible)	From Internet Search / Referral (patient) / Referral(clinic) / Magazine / Facebook

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE

ADDITIONAL INFORMATION/NOTES

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by ACURA Acupuncture Clinic is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor.

SIGNATURE _____ DATE _____

Medical History

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NAME (LAST, FIRST) | DATE

MAJOR COMPLAINT/HEALTH PROBLEM

HOW DID THIS CONDITION DEVELOP?

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? ☐ Yes ☐ No | IF YES, WHEN?

WHERE? | BY WHOM?

WHAT WAS THE DIAGNOSIS? | WHAT KIND(S) OF TREATMENT?

WHAT WERE THE RESULTS OF THE TREATMENT?

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG

LIST ANY MAJOR SURGERIES YOU HAVE HAD:

DATE	PROBLEM/SURGERY

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ AIDS
- ☐ Cancer
- ☐ Connective Tissue Disease
- ☐ Diabetes
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Stones
- ☐ Rheumatic Fever
- ☐ Ruptured Appendix
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Venereal Disease

Health History

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NAME (LAST, FIRST)	DATE

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

General
☐ Chills
☐ Low energy
☐ Dizziness
☐ Allergies
☐ Fatigue
☐ Fevers
☐ Excess thirst
☐ Insomnia
☐ Nervousness
☐ Numbness
☐ Sweat spontaneously
☐ Night sweating
☐ Lack of sweating
☐ Weight loss
☐ Weight gain
☐ Aversion to heat
☐ Aversion to cold

Head & Neck
☐ Blurred vision
☐ Heaviness in the head
☐ Headache
☐ Phlegm in throat
☐ Cataract
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Eye pain/strain
☐ Corrected vision
☐ Nasal obstruction
☐ Nasal discharge
☐ Loss of sense of smell
☐ Hearing loss
☐ Hoarseness
☐ Nosebleeds
☐ Recurrent sore throat
☐ Red/inflamed eye
☐ Ringing in ears
☐ Sinus problems
☐ Sores on lips
☐ Sores on tongue
☐ Taste change
☐ Teeth problems
☐ Vision – see halos

Respiratory
☐ Asthma
☐ Hay fever
☐ Persistent cough
☐ Coughing blood
☐ Shortness of breath
☐ Recurrent bronchitis
☐ Phlegm production
☐ Difficulty inhaling
☐ Difficulty exhaling

Cardiovascular
☐ Chest pain
☐ High blood pressure
☐ Low blood pressure
☐ Irregular heart beat
☐ Poor circulation
☐ Swelling of ankles
☐ Varicose veins
☐ Hypochondriac pain
☐ Distention in chest or hypochondrium

Gastrointestinal
☐ Abdominal pain
☐ Bloating
☐ Belching
☐ Gas
☐ Constipation
☐ Diarrhea/loose stools
☐ Bloody stools
☐ Black stools
☐ Difficulty swallowing
☐ Poor appetite
☐ Heartburn/reflux
☐ Hemorrhoids
☐ Indigestion
☐ IBS
☐ Stomachache
☐ Nausea
☐ Vomiting
☐ Vomiting blood

Diet/Lifestyle
☐ Vegetarian
☐ Healthy diet
☐ Eat much fried foods
☐ Eat much meat
☐ Smoke cigarettes
☐ Drink alcohol
☐ Drink coffee
☐ Use drugs
☐ Eat a lot of sweets
☐ Take melatonin
☐ Take steroids
☐ Exercise regularly
☐ Exercise excessively

Weight
☐ Underweight
☐ Normal for height
☐ Overweight
☐ Very overweight

Genitourinary
☐ Dilute urine
☐ Dark urine
☐ Blood in urine
☐ Cloudy urine
☐ Burning urination
☐ Scanty urine
☐ Profuse urine
☐ Frequent urination
☐ Poor bladder control
☐ Urgency to urinate

Musculoskeletal
Pain, weakness, numbness in:
☐ Arms
☐ Feet
☐ Hands
☐ Joints
☐ Legs
☐ Hips
☐ Neck
☐ Shoulders
☐ Pain all over
☐ Cold limbs
☐ Knee problems
☐ Low back pain
☐ All over weakness
☐ Lack of strength
☐ Broken bones

Skin
☐ Thick skin
☐ Thin skin
☐ Broken blood vessels
☐ Blood not clotting
☐ Bruise easily
☐ Discoloration
☐ Dark circles around eyes
☐ Bags under eyes
☐ Lumps in groin
☐ Lumps underarm
☐ Dry skin
☐ Acne
☐ Brittle nails
☐ Premature gray hair
☐ Dry, brittle hair
☐ Hair falling out

Neurologic
☐ Fainting
☐ Convulsions
☐ Handwriting change
☐ Paralysis
☐ Stroke
☐ Seizures
☐ Tremor
☐ Recent clumsiness
☐ Drowsiness
☐ Vertigo

Emotional
☐ Insomnia
☐ Irritability
☐ Often feel angry
☐ Troubling dreams
☐ Cry uncontrollably
☐ Feel sad a lot
☐ Forgetful
☐ Mind not clear
☐ Anxiety
☐ Much fear
☐ Unrestrained joy
☐ Terrors
☐ Difficulty expressing emotions

Men Only
☐ Genital pain
☐ Impotence
☐ Genital sores
☐ Lump in testicles
☐ Penis discharge
☐ Nocturnal emission
☐ Low sexual energy

Women Only
☐ Abnormal pap smear
☐ Bleed between periods
☐ Irregular periods
☐ Heavy periods
☐ <25 day cycle
☐ >35 day cycle
☐ Endometriosis
☐ Painful periods
☐ Premenstrual tension
☐ Breast lumps
☐ Contraceptives
☐ Sores on genitalia
☐ Low sexual energy
☐ Vaginal discharges
☐ Menopausal
☐ Uterine prolapse
☐ Facial hair
☐ Loss of head hair
☐ May be pregnant

Women's Fertility History

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NAME (LAST, FIRST)	DATE

Age at which menses began _____

Are your periods painful? ☐ Yes ☐ No

How many days does the pain last?_____

How many days do you normally bleed?_____

How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy

What color is the blood? ☐ Light red ☐ Red ☐ Dark red ☐ Purple ☐ Brown ☐ Black

Is there clotting? ☐ Yes ☐ No

Do you have premenstrual tension? ☐ Yes ☐ No

Does your face break out before or during your period? ☐ Yes ☐ No

Do your breasts become tender premenstrually? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Are your menstrual cycles spaced irregularly? ☐ Yes ☐ No

How many days are there from one period to the next?_____

Date of last menstrual period_____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been performed?	_____	_____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

Do you get yeast infections regularly? ☐ Yes ☐ No

Have you ever been diagnosed with a chlamydial infection? ☐ Yes ☐ No

Do you have chronic vaginal discharge? ☐ Yes ☐ No

Do you have any sores on your genitalia? ☐ Yes ☐ No

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No

Were you treated for it? ☐ Yes ☐ No

How_____

_____

Date of last Pap smear_____

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No

Have you been diagnosed with pelvic adhesions? ☐ Yes ☐ No

Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	**Reason**	**How long**

Have your cycles changed since they began? ☐ Yes ☐ No

How? _____

Do you ovulate on your own? ☐ Yes ☐ No

On what day of your cycle?_____

Do your breasts get tender at/during ovulation? ☐ Yes ☐ No

Do you get premenstral low back pain? Yes No

Do your bowel movements become loose at the beginning of you period? ☐ Yes ☐ No

Women's Fertility History *Continued*

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when and where?_____

By whom?_____

What types?_____

Have you taken medication to help you ovulate? ☐ Yes ☐ No

When _____ How long?_____

Have your fallopian tubes been evaluated medically? ☐ Yes ☐ No

What were the results?_____

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormone laboratory tests performed? ☐ Yes ☐ No

What were the results?_____

_____

Do you have a single partner
with whom you have been trying to conceive? ☐ Yes ☐ No

How long have you been married or living together?_____

Has he had a fertility workup? ☐ Yes ☐ No

What were the results?_____

Is your partner supportive of your wish to conceive? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No

When _____ How long?_____

Have you ever had an IUD? ☐ Yes ☐ No

When _____ How long?_____

Have you ever taken DepoProvera? ☐ Yes ☐ No

When _____ How long?_____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ☐ Yes ☐ No

What was it?_____

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you douche regularly? ☐ Yes ☐ No

With what?_____

Do you use vaginal lubricants? ☐ Yes ☐ No

Are you more than 20% over your ideal body weight? ☐ Yes ☐ No

Are you more than 20% below your ideal body weight? ☐ Yes ☐ No

Do you have a stressful occupation? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you have excessive facial hair? ☐ Yes ☐ No

Do you have excessively oily skin? ☐ Yes ☐ No

Have you experienced excessive loss of head hair? ☐ Yes ☐ No

Have you noticed discharge from your nipples? ☐ Yes ☐ No

Was your mother exposed to
diethylstilbestrol (DES) when she was pregnant with you? ☐ Yes ☐ No

Have you been exposed to any
known environmental toxins or hormones? ☐ Yes ☐ No

Are you presently taking steroids? ☐ Yes ☐ No

COMMENTS/NOTES

Name:_____
Date:_____

Health Check Chart

Please fill in **(2)** for **frequent symptoms** and **(1)** for **occasional symptoms**.

1		Tinnitus (ringing in the ears)	25		Headaches/head is heavy
2		Vertigo	26		Chest pain/constriction
3		Uneasy stomach	27		Depressed appetite
4		Random cold sweats	28		Irritated by repetitive activities
5		Diarrhea; constipation	29		Worry about personal health
6		Hot flashes; cold flashes	30		Eye strain
7		Nausea; vomiting	31		Depressed sexual desire
8		Cold hands and feet	32		Hard time falling asleep and easily woken up
9		Legs feel tired	33		Easily fall asleep, but easily woken up
10		lethargic (tired) when working	34		Throat feels closed
11		Difficulty breathing	35		Body is feels sluggish after waking up and tired in the afternoon
12		Heart palpitations	36		Loss of interest in daily activities
Sub			sub		
13		Nervous shakes/sweats	37		Forgetful
14		Bursts of anger due to minor situations	38		Often remember dreams
15		Face flushes randomly	39		Stomach hurts after meals/when empty
16		Confusion/panic during busy situations	40		Poor body condition during menstruation (pain, frustration, etc.)
17		Trouble focusing	41		Irregular period (too little/too heavy)
18		Feelings are easily hurt	42		Underweight/Overweight
19		Easily become emotional	43		Stiff shoulders and neck
20		Very sensitive to criticism	44		Pain in chest and back
21		Anxious about eating out	45		Numbness/pain in hands and feet
22		Become worrisome about trivial things	46		Stiff hands in the morning
23		Have been told that you are high strung	47		Swollen hands/feet in the morning
24		You often do things on a whim rather than thinking them through	48		Night sweats
Sub			49		Painful and continious coughing
			50		Poor body condition when the weather changes
Total			sub		