# South Tipperary Acupuncture

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Name: ________________________________________ Date of Birth: __ _/___/______ 1st appointment: ___/___/______

Address: ______________________________________ PH. ____________________ Blood Type: A / B / AB / O

Occupation: ______________________________ Email: ____________________________________________________

Place in family: ______________________________ No. of children & ages: _______________________________________

GP: _______________________________________ Ph: ___________________________ Last visit: ___/___/_____

Emergency Contact:______________________________ ICE#: ___________________________

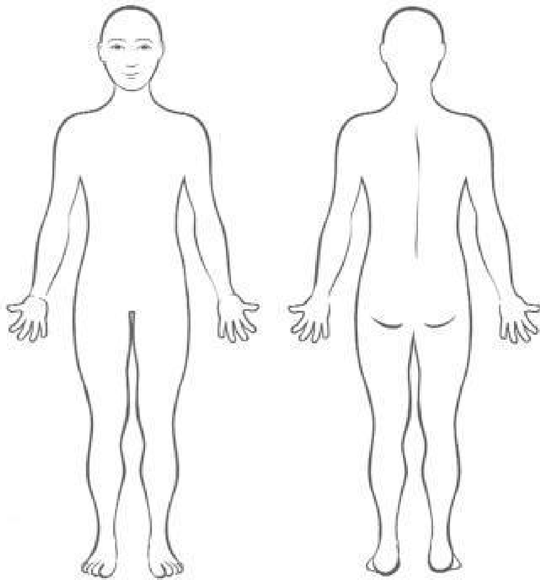
Have you ever had acupuncture before? Yes / No

GP/Consultant's diagnosis: _______________________

**Reason for this visit**: __________________________________________

Other medical treatments received: physio/chiro/osteo/other:______

Please mark the areas of concern/pain:



Circle discomfort/pain level: (None) 1 2 3 4 5 6 7 8 9 10 (unbearable)

What relieves the condition? (activity, rest, ice, heat...)____________________

What aggravates the condition? (weather, heat, cold..)____________________

Are you awaiting surgery? ____________________________________________

List prescription drugs or over the counter drugs currently taking:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

List supplements currently taking: _____________________________________

____________________________________________________________________

____________________________________________________________________

List any allergies (food, drugs, environmental, etc.): ______________________

____________________________________________________________________

____________________________________________________________________

Details of hospitalisation for any serious condition/surgeries:______________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

For the following please indicate quantity? And how often you consume them?

Cigarettes: ____ /____ Alcohol: ____ /_____ Drugs: ____/_____ Caffeine: ____/_____ Fizzy drinks: ____/_____ Water: ___/___

What exercise do you engage in & frequency? __________________________________________________________________________

How would you rate your daily energy between 1 and 10 (10 being best)? ______

List your main health concerns in order of importance to you:

1. ____________________________________________________________________________________________
2. ____________________________________________________________________________________________
3. ____________________________________________________________________________________________
4. ____________________________________________________________________________________________

Please give any other relevant information or issues you think relevant or would like to discuss:

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Please print, complete and return before your initial appointment. Thank you

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**Family Medical History:** Please indicate with a **P** (past) **C** (current) **F** (family) if any of the conditions below apply:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Low Blood Pressure | | Epilepsy | | Jaundice | | Arthritis | |
| High Blood Pressure | | Dizziness/Fainting | | Jaw pain | | Cancer | |
| Heart condition | | Lung condition | | Hepatitis | | Endometriosis | |
| Thrombosis/Embolism | | Skin condition | | Headaches/Migraine | | Uro/Gynae _____________ | |
| Wear a Pacemaker | | Osteoporosis | | Cataracts/ Macular degeneration | | Digestive disorder________ | |
| Stroke | | Diabetes | | Kidney condition | | Other _________________ | |

**Patient Medical History:** Please indicate severity of current symptoms, rated 1-10 (10 being worst). Leave blank if N/A

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **LV/GB** | | Lack of joy in life | | Blood in stool | | Weak immune system | |
| Depression | | Bitter taste in mouth | | Can go hours without food | | Alternate chills/fever | |
| Stress | | High blood pressure | | Large appetite | | Grief/sadness | |
| Floaters in eyes | | Irregular heart beat | | Crave sweets | | Shortness of breath | |
| Poor night/blurred vision | | Restless/agitated | | Water retention | | Sweating during day | |
| Itchy/ dry/red eyes | | Anxiety | | Overweight | | **KD/BL** | |
| Dizziness | | Aversion to heat | | Pensive/overthinking | | Frequent urination | |
| Feels like lump in throat | | Tingling fingers/toes | | Tend to worry | | Leaking urine | |
| Discomfort at sides under ribs | | | | Sweating on forehead | | Urgency to urinate | |
| Neck/shoulder tension | | **SP/ST** | | Foggy mind | | Bladder infections | |
| Muscle twitching/spasm | | Constipation | | Yeast infections | | Painful urination | |
| Brittle nails | | Loose stools | | Always cold | | Wake to urinate | |
| Sighing | | Alternates constipation/loose | | Prefer warm food | | Bring water to bed | |
| PMS | | Nausea/vomiting | | Prefer warm drinks | | Low sex drive | |
| Genital itching/pain/rashes | | Bloating/gas | | Cold feet, warm hands | | High sex drive | |
| Headaches/Migraines | | Intestinal pain/cramping | | Cold feet, cold hands | | Kidney stones | |
| Emotional eating | | Stool marks toilet bowl | | Snoring | | Dark urine | |
| Irritable/frustrated/impatient | | Abdominal pain | | Tiredness/fatigue | | Smelly urine | |
| Gallstones | | Heartburn | | **LU/LI** | | Loss of head hair | |
| Nightmares | | Indigestion | | Sinusitis/congestion | | Hearing problems | |
| Clenching teeth | | Belching/burping | | Cough with phlegm | | Tinnitus | |
| **HT/SI** | | Heaviness in head/body | | Dry cough | | Fear | |
| Chest pain/tightness | | Tired after eating | | Nasal drip | | Bad longterm memory | |
| Disturbed sleep/Insomnia | | Difficult getting up in a.m. | | Dry mouth/nose | | Swollen ankles | |
| Difficulty going to sleep | | Tired/weak muscles | | Sore throat | | Crave salty foods | |
| Mind racing | | Bruise easily | | Skin rashes | | Night sweats/hot flush | |
| Palpitations | | Bad breath | | Asthma/wheezing | | Lower back/knee pain | |
| Vivid dreams | | Bleeding gums | | Cough up blood | | Very thirsty | |
| Mouth/tongue/lip ulcers | | Haemorrhoids | | Catch cold easily | | No thirst | |
| Forgetful | | Nose bleeds | | Hay fever | | Osteoporosis/penia | |

**For Men Only**

Prostate Problems_____ Pain in testicles ____ Erectile Dysfunction _____ BPH ______ Varicocele ____

**For Women Only**

Age@ first period _____
Day in cycle today _____
Duration of typical period _____
# of pregnancies _____
# of miscarriages _____
# of live births _____
Irregular Period _____
Painful periods ____
Bleeding between periods _____
Breast pain _____
Period clots _____

Colour of blood _____
Birth control (BC) _____
Type of BC _____
How long this BC method _____
Menopause _____
Age @menopause _____
Taking HRT _____
Vaginal dryness _____
Excess vaginal discharge _____

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