FIRST NAME LAST NAME

ADDRESS

CITY STATE ZIP

HOME PHONE OTHER PHONE

EMAIL OCCUPATION

DATE OF BIRTH AGE SEX WEIGHT

PHYSICIAN'S NAME PHYSICIAN'S PH#

PHYSICIAN'S ADDRESS

REFERRED BY

PRIMARY COMPLAINT

ACUTE HEALTH PROBLEMS

CHRONIC HEALTH PROBLEMS
(onset & frequency)

CURRENT & PAST TREATMENTS
(include medications, herbs, vitamins. dates used.)

SURGERY
(type and age)

FREQUENT OR SERIOUS CHILD-HOOD ILLNESS
(age of occurrence)

EXERCISE
(type and frequency)

RECREATION
(type and frequency)

SIGNIFICANT TRAUMA
(include years] involved - falls, accidents, emotional or physical abuse)

EMOTIONS
(choose two that seem predominant in your life.)

INDICATE WITH ONE CHECK ANY CONDITION THAT YOU SOMETIMES EXPERIENCE; USE TWO CHECKS FOR THOSE THAT OCCUR OFTEN; AND THREE CHECKS FOR SYMPTOMS THAT ARE A MAJOR CONCERN.

WATER ELEMENT:

☐☐☐ HEARING LOSS
☐☐☐ DIZZINESS
☐☐☐ LOWER BACK ACHE/NECK PAIN
☐☐☐ SINUS CONGESTION
☐☐☐ EDEMA
☐☐☐ DARKNESS UNDER EYES
☐☐☐ EMOTIONAL INSTABILITY
☐☐☐ AVERSION TO COLD
☐☐☐ HAIR THINNING AND/OR LOSS
☐☐☐ PRE-MATURE AGING
☐☐☐ FREQUENT URINATION
☐☐☐ KIDNEY STONES
☐☐☐ PERSPIRE VERY EASILY
☐☐☐ WEAKNESS OF LEGS/KNEES
☐☐☐ ASTHMATIC COUGH
☐☐☐ RAPID WEIGHT CHANGE
☐☐☐ LOOSE TEETH
☐☐☐ REDUCED SEXUAL ENERGY
☐☐☐ THYROID PROBLEMS
☐☐☐ DIABETES

EARTH ELEMENT:

☐☐☐ INDIGESTION
☐☐☐ FLATULENCE
☐☐☐ FOOD ALLERGY
☐☐☐ STOMACH ULCER
☐☐☐ DIARRHEA
☐☐☐ ANEMIA
☐☐☐ HALITOSIS
☐☐☐ SORES IN MOUTH
☐☐☐ HEARTBURN
☐☐☐ STRONG APPETITE
☐☐☐ WEAK APPETITE
☐☐☐ NAUSEA
☐☐☐ ABDOMINAL BLOATING
☐☐☐ LOW BODY WEIGHT

WOOD ELEMENT:

☐☐☐ HEADACHES
☐☐☐ MIGRAINES
☐☐☐ RINGING IN THE EARS
☐☐☐ POOR EYESIGHT
☐☐☐ EYE INFECTION
☐☐☐ DRY EYES
☐☐☐ ECZEMA, ETC.
☐☐☐ SHINGLES
☐☐☐ HERPES SIMPLEX
☐☐☐ WARTS
☐☐☐ NERVOUSNESS
☐☐☐ CONVULSION, SPASMS
☐☐☐ IRRITABILITY
☐☐☐ CONSTIPATION
☐☐☐ HEMORRHOIDS
☐☐☐ HEPATITIS
☐☐☐ ULCER
☐☐☐ VOMITING
☐☐☐ GALLSTONES
☐☐☐ INDECISIVE
☐☐☐ FULLNESS BELOW RIBS
☐☐☐ SHOULDER/NECK TENSION
☐☐☐ INSOMNIA 11pm - 3am

METAL ELEMENT:

☐☐☐ BRONCHITIS
☐☐☐ ASTHMA
☐☐☐ SHALLOW BREATHING
☐☐☐ COUGH
☐☐☐ SINUS CONGESTION
☐☐☐ NASAL INFECTIONS
☐☐☐ SPONTANEOUS SWEATING

FIRE ELEMENT:

☐☐☐ DRY SCALP
☐☐☐ SKIN ERUPTIONS, RASH
☐☐☐ CYSTS, TUMORS
☐☐☐ EAR INFECTION
☐☐☐ SORE THROAT, TONSILLITIS
☐☐☐ LUMP SWELLING
☐☐☐ HOT PALMS, SOLES
☐☐☐ HEART PALPITATION
☐☐☐ AVERSION TO HEAT
☐☐☐ BITTER TASTE IN TOUCH
☐☐☐ GUM PROBLEM
☐☐☐ NOSE BLEED
☐☐☐ FACIAL REDNESS
☐☐☐ ITCHING/BURNING SKIN
☐☐☐ HOT HANDS/FEET
☐☐☐ THIRST
☐☐☐ VIVID-DREAMING
☐☐☐ DARK URINE
☐☐☐ NIGHT SWEATS

OTHER:

☐☐☐ FATIGUE
☐☐☐ ARTHRALGIA
☐☐☐ SCIATICA NERVE PAIN
☐☐☐ COLD HANDS/FEET
☐☐☐ TENDONITIS
☐☐☐ BURSITIS

I TAKE THE FOLLOWING MEDICATIONS:

MEDICATION	DOSAGE	PER DAY	WEEKLY	MONTHLY	AS NEEDED

I TAKE THE FOLLOWING VITAMINS AND/OR DIETARY SUPPLEMENTS:

SUPPLEMENT	DOSAGE	PER DAY	WEEKLY	MONTHLY	AS NEEDED

I TAKE THE FOLLOWING HERBAL SUPPLEMENTS OR FORMULAS:

HERBS	DOSAGE	PER DAY	WEEKLY	MONTHLY	AS NEEDED

SELF MEDICAL HISTORY: include dates

_____ CANCER	_____ TENSION/ANXIETY	_____ DRUG ADDICTION
_____ DIABETES, HYPOGLYCEMIA	_____ ARTHRITIS	_____ EATING DISORDER
_____ HIGH BP/LOW BP	_____ URINARY TRACK INFECTION	_____ CIGARETTE ADDICTION
_____ HEART DISEASE	_____ KIDNEY DISEASE	_____ ALCOHOLISM
_____ HEPATITIS	_____ VENEREAL DISEASE	_____ TB
_____ MONONUCLEOSIS	_____ HERPES	_____ HIV
_____ GI PROBLEMS	_____ HPV (papilloma virus)	_____ AIDS
_____ SEIZURES	_____ CANDIDA	_____ PARASITES
		_____ HYPO/HYPER THYROID

MOTHER/FATHER MEDICAL HISTORY: include dates

_____ CANCER	_____ TENSION/ANXIETY	_____ DRUG ADDICTION
_____ DIABETES, HYPOGLYCEMIA	_____ ARTHRITIS	_____ EATING DISORDER
_____ HIGH BP/LOW BP	_____ URINARY TRACK INFECTION	_____ CIGARETTE ADDICTION
_____ HEART DISEASE	_____ KIDNEY DISEASE	_____ ALCOHOLISM
_____ HEPATITIS	_____ VENEREAL DISEASE	_____ TB
_____ MONONUCLEOSIS	_____ HERPES	_____ HIV
_____ GI PROBLEMS	_____ HPV (papilloma virus)	_____ AIDS
_____ SEIZURES	_____ CANDIDA	_____ PARASITES
		_____ HYPO/HYPER THYROID

OTHER MEDICAL HISTORY: include dates of other family members

_____ CANCER	_____ TENSION/ANXIETY	_____ DRUG ADDICTION
_____ DIABETES, HYPOGLYCEMIA	_____ ARTHRITIS	_____ EATING DISORDER
_____ HIGH BP/LOW BP	_____ URINARY TRACK INFECTION	_____ CIGARETTE ADDICTION
_____ HEART DISEASE	_____ KIDNEY DISEASE	_____ ALCOHOLISM
_____ HEPATITIS	_____ VENEREAL DISEASE	_____ TB
_____ MONONUCLEOSIS	_____ HERPES	_____ HIV
_____ GI PROBLEMS	_____ HPV (papilloma virus)	_____ AIDS
_____ SEIZURES	_____ CANDIDA	_____ PARASITES
		_____ HYPO/HYPER THYROID

ALLERGIES
(include medication,food,
environment and chemicals) _____

DIET: please note foods you eat with frequency. One check- occasionally.
Two checks- daily. Also note foods you avoid with an 'A'

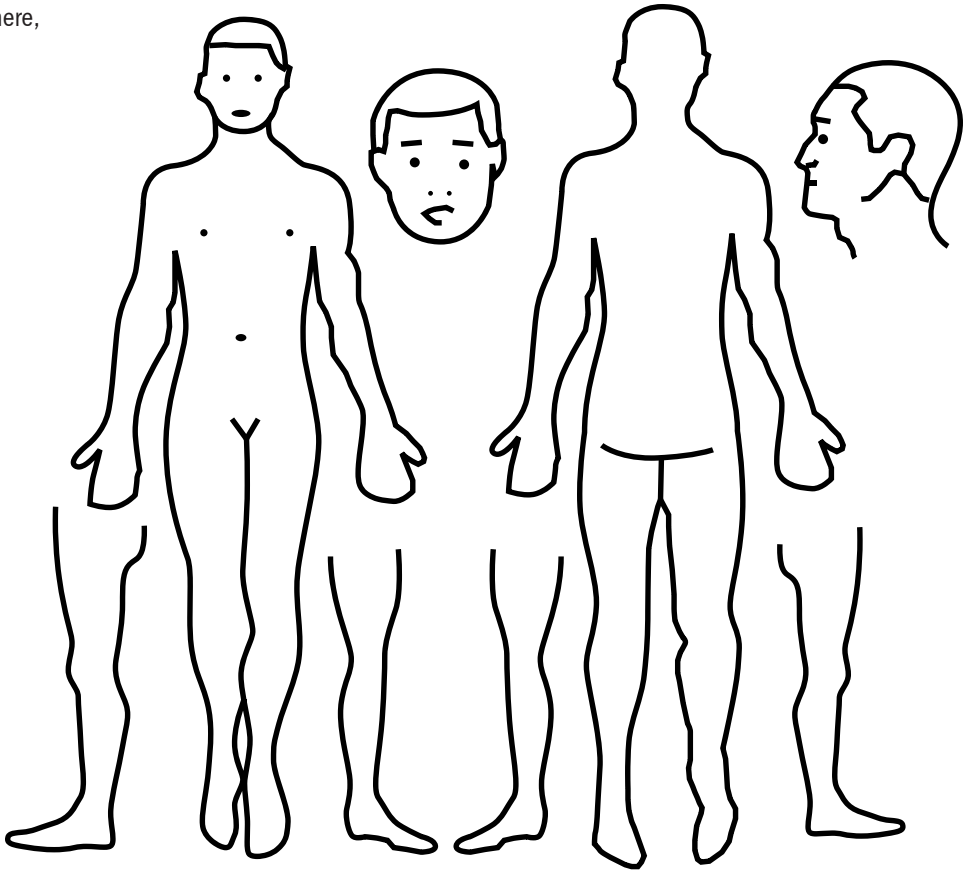
☐ ☐ COFFEE/TEAS	☐ ☐ CHICKEN	☐ ☐ GRAINS	☐ ☐ SWEETS
☐ ☐ SODA/SELTZER	☐ ☐ RED MEATS	☐ ☐ VEGETABLES	☐ ☐ PREPARED FOODS
☐ ☐ ALCOHOL	☐ ☐ FISH	☐ ☐ VEG. JUICES	☐ ☐ BREADS
☐ ☐ MILK/CHEESE	☐ ☐ LEGUMES	☐ ☐ FRUITS	☐ ☐ SPICY FOODS
☐ ☐ YOGURT	☐ ☐ SOY PRODUCTS	☐ ☐ FRUITS JUICES	☐ ☐ COLD FOODS
	☐ ☐ NUTS	☐ ☐ SEAWEED	
	☐ ☐ NUTS BUTTERS		

I generally eat:

☐ ☐ IRREGULAR MEALS	☐ ☐ REGULAR MEALS
☐ ☐ OUT	☐ ☐ IN

PAIN: if pain is involved, describe and indicate where, use illustration below

- ☐ COME ON GRADUALLY
- ☐ CAME ON SUDDENLY
- ☐ SLIGHT OR DULL
- ☐ SHARP OR STABBING
- ☐ MOVES FROM PLACE TO PLACE
- ☐ FIXED IN ONE LOCATION
- ☐ ALLEVIATED WITH HEAT
- ☐ ALLEVIATED WITH COLD
- ☐ RELIEVED WITH TOUCH
- ☐ AGGRAVATED BY TOUCH
- ☐ WORSE WITH FATIGUE
- ☐ BETTER AFTER EXERCISE



URINATION:

NIGHT VOIDING:

UNUSUAL DISCHARGE:

DAY FREQUENCY:

RETENTION:

AMOUNT:

COLOR:

BLOOD:

PAIN:

DIFFICULTY TO START:

DIFFICULTY TO PASS:

DRIBBLING AFTER URINATION:

BOWELS:

FREQUENCY:

TEXTURE/FORM:

COLOR:

BLOOD:

HEMORRHOIDS:

MUCOUS IN STOOL:

PAIN/DIFFICULTY IN PASSING:

DIFFICULTY TO START:

MALES ONLY:

DATE OF LAST PROSTATE EXAM:

PLEASE INDICATE YOUR EXPERIENCES OF THE FOLLOWING:

PROSTATE:

KIDNEY INFECTIONS:

BLADDER INFECTIONS:

PAIN/ITCHING IN GENITAL AREA:

HPV (warts):

GENITAL HERPES:

BURNING URINATION:

FREQUENT URINATION:

URINARY TRACT INFECTION:

NOCTURNAL EJACULATION:

INCOMPLETE EJACULATION:

PREMATURE EJACULATION:

PAIN AFTER EJACULATION:

COLOR OF EJACULATION:

AMOUNT OF EJACULATION:

IMPOTENCE:

INCOMPLETE ERECTION:

NOTES:

FEMALES ONLY:

PLEASE INDICATE YOUR EXPERIENCES OF THE FOLLOWING:

URINARY TRACT INFECTION:

BLADDER INFECTION:

VENEREAL DISEASE:

HERPES SIMPLEX:

YEAST INFECTION:

PID:

INFERTILITY:

FIBROIDS:

OVARIAN CYSTS:

VAGINAL DISCHARGE

COLOR:

ODOR:

CONSISTENCY:

WHEN:

GYN SURGERIES:

NUMBER OF PREGNANCIES:

NUMBER OF MISCARRIAGES:

NUMBER OF ABORTIONS:

DATE OF LAST PAP:

POSITIVE PAP DATE:

PERIODS:

AGE OF ONSET:

BLOATING:

CRAMPING:

EDEMA:

DESCRIBE AMOUNT, COLOR AND ODOR (IF ANY) OF MENSTRUAL FLOW:

DAY 1:

DAY 4:

DAY 2:

DAY 5:

DAY 3:

DAY 6:

PRESENT AND PAST BIRTH CONTROL METHODS:

NOTES:

FEMALES ONLY:

GRADING OF SYMPTOMS:

1: NONE 2: MILD 3: MODERATE 4: SEVERE

	SYMPTOMS	WEEK AFTER PERIOD:		WEEK BEFORE PERIOD:	
	NERVOUS TENSION:				
	MOOD SWINGS:				
PMT-A	IRRITABILITY:				
	ANXIETY				
	WEIGHT GAIN:				
	SWELLING OF EXTREMITIES:				
PMT-H	BREAST TENDERNESS:				
	ABDOMINAL BLOATING:				
	HEADACHE:				
	CRAVING FOR SWEETS:				
	INCREASED APPETITE:				
PMT-C	HEART POUNDING:				
	FATIGUE:				
	DIZZINESS OR FAINTING:				
	DEPRESSION:				
	FORGETFULNESS:				
PMT-C	CRYING:				
	CONFUSION				
	INSOMNIA				
	OILY SKIN				
OTHER	ACNE:				
	MENSTRUAL CRAMPS:				
	MENSTRUAL BACKACHE				

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I, the undersigned, hereby assume full responsibility for any acupuncture energetic therapies engaged in by myself or with the therapist, as well as any self-help suggestions I may choose to follow. All therapies are a result of conclusions as a result of what I have learned from the above energetic assessment and are not treatments administered to me for medical and psychiatric disorders. The goal of the above therapies is to restore energetic integrity or my body and should any medical or psychiatric problem arise, I assume full responsibility to consult with the appropriate physicians and seek whatever treatment is indicated.

I am aware that acupuncture/moxabustion is a form of treatment based on the principles and theories of Traditional Chinese Medicine. I am aware that acupuncture therapy involves the insertion of special acupuncture needles into specific acupuncture points on the human body.

I have been made aware of the possibility of bruising, bleeding, faintness, nausea, areas of anesthesia, organ puncture, needle breakage and/or retention that may result, although unlikely, from the above procedure.

I hereby certify that I understand that the above authorization and conditions. I have read, or have had read to me, the above consent. I have had an opportunity to ask questions about its content. I hereby give my voluntary consent for the administration of acupuncture or moxabustion to me. I am aware that I may stop acupuncture treatment at any time.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR	DATE
SIGNATURE OF LICENSED ACUPUNCTURIST	DATE

We, the undersigned, do affirm that _____,
PRINT PATIENT NAME
has been advised by Laura Gabbe, LAc., to consult a physician regarding the condition or conditions for which such patient seeks acupuncture.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR	DATE
SIGNATURE OF LICENSED ACUPUNCTURIST	DATE