



MAPLE VALLEY ACUPUNCTURE
AND HERBAL MEDICINE

23745 225th Way SE St. Suite 107 • Maple Valley, WA 98038 • 425-413-3801

Personal Information

Name: _____ Date: _____

Primary Phone: _____ OK to leave messages? Y N Text? Y N

Address: _____

E-mail Address: _____ OK to send e-mails? Y N

Age: _____ Date of Birth: _____ Marital Status: _____

Height: _____ Weight: _____ Gender: _____ Occupation: _____

Primary Care Provider: _____ Phone: _____

Emergency Contact: _____ Phone: _____

How did you hear about Maple Valley Acupuncture? _____

Health History

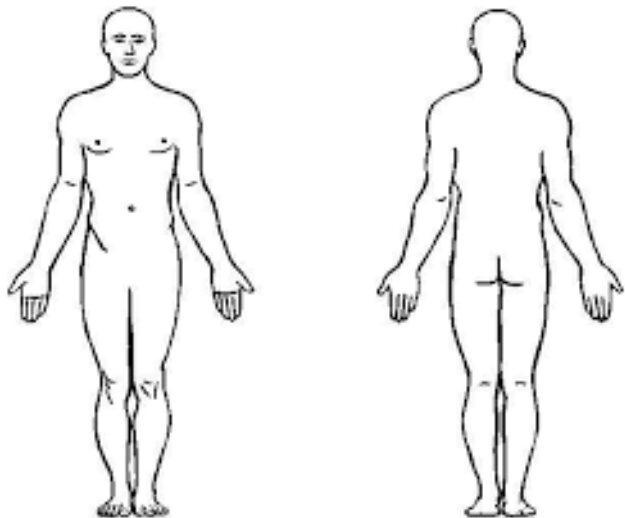
Main issue(s) you would like help with:

How long ago did this begin (be specific):

To what extent does this problem interfere with your daily life (sleep, work, exercise, etc.)?

What types of treatments have you tried?

Where does this issue affect you (if applicable?)



If you're dealing with pain, what would you rate your pain on a scale of 0-10 (0= none at all, 10= excruciating, can't do anything)?

Please check any symptoms that you have experienced in the past or currently experience:

General

	past	current		past	current
sweating easily during the day	<input type="checkbox"/>	<input type="checkbox"/>	fatigue	<input type="checkbox"/>	<input type="checkbox"/>
night sweating	<input type="checkbox"/>	<input type="checkbox"/>	fevers	<input type="checkbox"/>	<input type="checkbox"/>
bleed or bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	chills	<input type="checkbox"/>	<input type="checkbox"/>
change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	poor sleep	<input type="checkbox"/>	<input type="checkbox"/>

Skin & Hair

	past	current		past	current
rashes/hives	<input type="checkbox"/>	<input type="checkbox"/>	psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
eczema	<input type="checkbox"/>	<input type="checkbox"/>	loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
acne	<input type="checkbox"/>	<input type="checkbox"/>			

Head, Ears, Eyes, Nose & Throat

	past	current		past	current
earaches/pressure in the ears	<input type="checkbox"/>	<input type="checkbox"/>	headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>
ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>
hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
eye floaters	<input type="checkbox"/>	<input type="checkbox"/>	dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>
itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	teeth/jaw clenching	<input type="checkbox"/>	<input type="checkbox"/>
blurry vision	<input type="checkbox"/>	<input type="checkbox"/>			

Cardiovascular/Circulatory

	past	current		past	current
chest pain	<input type="checkbox"/>	<input type="checkbox"/>	swelling/edema	<input type="checkbox"/>	<input type="checkbox"/>
fainting	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cold hands & feet	<input type="checkbox"/>	<input type="checkbox"/>			

Respiratory

	past	current		past	current
pain on inhaling	<input type="checkbox"/>	<input type="checkbox"/>	sneezing	<input type="checkbox"/>	<input type="checkbox"/>
chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	seasonal/other allergies	<input type="checkbox"/>	<input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>	phlegm production	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input type="checkbox"/>	<input type="checkbox"/>			

Genito-Urinary

	past	current		past	current
difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	urgent/frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	sores on genitals	<input type="checkbox"/>	<input type="checkbox"/>
pain upon urination	<input type="checkbox"/>	<input type="checkbox"/>	genital pain	<input type="checkbox"/>	<input type="checkbox"/>

Neurological/Psychological

	past	current		past	current
anxiety	<input type="checkbox"/>	<input type="checkbox"/>	poor memory	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>	quick temper	<input type="checkbox"/>	<input type="checkbox"/>
loss of balance/coordination	<input type="checkbox"/>	<input type="checkbox"/>	easily susceptible to stress	<input type="checkbox"/>	<input type="checkbox"/>
areas of numbness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>			

Digestive

	past	current		past	current
heartburn	<input type="checkbox"/>	<input type="checkbox"/>	gas	<input type="checkbox"/>	<input type="checkbox"/>
belching	<input type="checkbox"/>	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
bloating	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>
nausea	<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>
vomiting	<input type="checkbox"/>	<input type="checkbox"/>	mucus in stool	<input type="checkbox"/>	<input type="checkbox"/>
chronic bad breath	<input type="checkbox"/>	<input type="checkbox"/>	blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
sores on lips/tongue	<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

For Women Only:

	past	current		past	current
irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	breast pain	<input type="checkbox"/>	<input type="checkbox"/>
painful periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	vaginal sores	<input type="checkbox"/>	<input type="checkbox"/>
period clots	<input type="checkbox"/>	<input type="checkbox"/>	hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
menstrual cramping	<input type="checkbox"/>	<input type="checkbox"/>	night sweating	<input type="checkbox"/>	<input type="checkbox"/>

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

of pregnancies _____ # of live births _____

of miscarriages _____ # of abortions _____

Have you been through menopause? At what age? _____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

For Men Only:

	past	current		past	current
erectile dysfunction/impotence	<input type="checkbox"/>	<input type="checkbox"/>	ejaculatory pain	<input type="checkbox"/>	<input type="checkbox"/>
varicocele	<input type="checkbox"/>	<input type="checkbox"/>	BPH	<input type="checkbox"/>	<input type="checkbox"/>

Lifestyle

Current medications/herbs/supplements:

Describe your meals during a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Other: _____

Current exercise routine (if any):

Do you drink alcohol? How many drinks per week?

Do you use tobacco? What kind and how much/many per day?

Do you use recreational drugs? What kind and how often?

Allergies (medications/foods/chemicals/etc.):

Surgeries and Hospitalizations (type and date):

Significant Trauma (falls, injuries, auto accidents, concussions, etc.):

Have you ever had a seizure? If yes, indicate date of last: _____

Please circle any significant illnesses and indicate date:

Cancer

Hepatitis

Diabetes

High blood pressure

Epilepsy

Heart Attack

Stroke

Ulcer Disease

Liver Disease

Colon Polyps

Other _____

Family Medical History

Cancer Seizures High blood pressure Stroke

Diabetes Heart Attack Hepatitis Asthma Other _____

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