

The Rock Clinic Association

Acupuncture Assessment and Medical History

Name:

Date:

Address:

Age:

Date of Birth:

Telephone no (home):

work:

mobile:

E-mail:

GP Name and address:

Occupation:

Presenting problem:

(if as a result of a stroke please give dates and after effects)

Pain:

(include location and type e.g. sharp, dull, intermittent etc)

Loss of function:

(include where and any changes)

Past Medical History

(short description of any illnesses, operations, accidents or shock with dates.)

Family History

(as above)

General Diagnosis

(please tick all that apply)

1. Do you suffer from:

- Coughs and colds?
- Dizziness?
- Blurred vision or floaters?
- Ear infections or pain as a child or more recently?
- Throat infections as child or more recently?
- Sinus problems?
- Mouth ulcers?
- Teeth problems?

2. Digestion: Do you

Have a good appetite?

Drink water juice tea coffee alcohol

(please state how many glasses/mugs per day)

Smoke ?

(please state how many per day?)

Have any burping or belching ?

Have any acid reflux wind

Pain or tightness in your stomach ribs lower abdomen

Are your bowels regular pale dark hard soft

Is your urination normal smelly dark pale

Have recurrent cystitis thrush

Ever have night sweats sweat a lot often feel slightly clammy rarely sweat

Have warm cold hands and feet

(if cold please state which feels worse hands or feet?)

Have any allergies

3. Sleep: Do you
 get to sleep easily _ sleep all night _ wake early _
 have any recurrent dreams _ vivid dreams _ nightmares _

4. Do your fingernails
 grow well _ become soft _ break easily _

5. Do you wear more _ less _ than others around you
(for example are you a 'warm' person who rarely needs a coat, or a 'cold' person who is always well wrapped up)

6. Flavours and tastes
 Please tick the one you most like avoid
 Sweet _ _
 Sour _ _
 Bitter _ _
 Salty _ _
 Pungent (like curry) _ _

7. Climates
 Please tick the one you most love avoid
 Heat _ _
 Dampness _ _
 Dry _ _
 Wind _ _
 Cold _ _

8. Emotions
 Are you fairly steady _ change swiftly from one feeling to another? _

Women only

9. Please describe your normal menstrual cycle :
 How often do you have your period ?
 How often do you bleed for ?
 Do you bleed excessively _ very little _
 Are there any clots? small _ pea size _ large _
 Is your menstrual blood bright red _ red _ dark red _
 Do you have any PMT: swollen breasts _ abdomen _
 Do you become emotional: angry _ irritable _ depressed _
 Do you suffer low back pain _ abdominal cramps _

10. Are you on the pill (if so please give date of starting)
 How many times have you been pregnant ?
 Have you had any miscarriages _ terminations _
 If continuing with the pregnancy please describe any problems during the pregnancies or in labour

Did you breastfeed?
 (if so please give date of stopping)