Kathryn Tooker, L.Ac.   Acupuncture & Chinese Herbal Medicine

Eastlake Clinic
1500 Fairview Ave E, Suite 205
Seattle, WA 98102

www.tookeracupuncture.com
(206) 518-7631

Ballard/Crownhill Clinic
1407 NW 70th St
Seattle, WA 98117

Today's date ________________

Name____ Nickname____________________________

Phone (primary)___________________________(secondary)____________________________

Address _______________________________ City ______________ State _____ Zip ________________

Email Address ______________________________________

Would you like a reminder before your appointment?__________ email or phone reminder? (circle one)

Age _______ Date of Birth ______________________________________

Gender____

Place of Birth _______________________________

Height ________ Weight _________ Marital/Partnership Status ________________________________

Employer Name ____

Family Physician ____________________________ Referred By ________________________________

Emergency Contact ______________________________________ Phone_________________________

Have You Been Treated By Acupuncture or Oriental Medicine Before?: Yes No

Main Problem(s) you would like help with ____

____

How long ago did this problem begin (be specific)? ____

____

To what extent does this problem interfere with your daily activities (work, sleep, etc)? _______________

____

Have you been given a diagnosis for this problem: If so, what? __________________________________

____

What kinds of treatment have you tried? ____

____

Past Medical History (please include date): Cancer ________ Diabetes _______ Hepatitis ______

High Blood Pressure ______ Heart Disease ______ Rheumatic Fever ______ Thyroid Disease ________

Seizures ______ Venereal Disease _______ HIV/AIDS ________ Other __________________________

Surgeries (type of and date)____

____

Significant Trauma (auto accidents, falls, etc) ____

____

Significant Dental Work (type and date)____

Allergies (drugs, chemicals, foods/result) ____

Family Medical History (check): Diabetes Cancer High Blood Pressure

Heart Disease Stroke Seizures Asthma Allergies

Other ____

Medicines taken within the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement	Reason for Taking It
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Occupational Stress (physical, chemical, psychological, etc) ____

____

Do you have a **regular exercise program**? Yes No Please Describe ____________________

____

Have you ever been on a **restricted diet**?Yes No What Kind? ____________________

____

Please describe your **average daily diet**:

Morning____

Afternoon____

Evening____

How many **packs of cigarettes** do you smoke per day? ____________________

How much **coffee, tea or cola** do you drink per day? ______________________________

How much **alcohol** do you drink per week? ______________________________

Please describe any use of recreational drugs ______________________________

Please check any you have had in the last three months:

General

- Poor appetite
- Fevers
- Sweat easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Sudden energy drop – what time of day? ________
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Night sweats
- Cravings
- Change in appetite
- Weight gain
- Weight loss

Skin and Hair

- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Recent moles
- Other hair or skin problems

Head, Eyes, Ears, Nose, and Throat

- Dizziness
- Glasses
- Poor vision
- Cataracts
- Ringing in ears
- Sinus problems
- Grinding teeth
- Teeth problems
- Concussions
- Eye strain
- Night blindness
- Blurry vision
- Poor hearing
- Nose bleeds
- Facial pain
- Jaw clicks
- Migraines
- Eye pain
- Color blindness
- Earaches
- Spots in front of eyes
- Recurrent sore throats
- Sores on lips or tongue
- Headaches - where and when ________________ ______________________
- Other head or neck problems ______________ ______________________

Cardiovascular

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Phlebitis
- Chest pain
- Fainting
- Swelling of feet
- Difficulty in breathing
- Other heart or blood vessel problems ______________ ______________________

Respiratory

- Cough
- Bronchitis
- Difficulty in breathing when lying down
- Production of phlegm what color _____________
- Coughing blood
- Pneumonia
- Asthma
- Pain with a deep breath
- Other lung problems _____ ______________________

Approximately when was your last cold or flu?__________

Gastrointestinal

- Nausea
- Constipation
- Black stools
- Bad breath
- Abdominal pain or cramps
- Chronic laxative use
- Vomiting
- Gas
- Blood in stools
- Rectal pain
- Diarrhea
- Belching
- Indigestion
- Hemorrhoids
- Other stomach or intestinal problems ______________ ______________________

Genito-urinary

Pain on urination
Urgency to urinate
Frequent urination
Unable to hold urine
Impotency
Blood in urine
Kidney stones
Sores on genitals
Other genital or urinary system problems ________

____

Do you wake up to urinate?
Yes No.
How often?

____

Any particular color to your urine? ________________

Pregnancy and Gynecology

Number of pregnancies ____
Number of births _________
Premature births _________
Miscarriages _____________
Abortions _______________
Age at first menses _______
Days between menses _____
Duration ________________
First day of last menses ____

____

Unusual character (heavy or light)
Painful periods
Vaginal discharge
What color?____________
Changes in body/psyche prior to menstruation
Clots
Vaginal sores
Irregular periods
Last Pap ______________
Breast lumps

Are you sexually active?___________________

Do you practice birth control?
Yes No N/A
What type and for how long?

____

Musculoskeletal

Neck pain
Back pain
Hand/wrist pain
Muscle pain
Muscle weakness
Shoulder pain
Knee pain
Foot/ankle pain
Hip pain

Neuropsychological

Seizures
Areas of numbness
Concussion
Bad temper
Dizziness
Lack of coordination
Depression
Easily susceptible to stress
Loss of balance
Poor memory
Anxiety
Other neurological or psychological problems

____

____

Please note the severity of your problem now:

No Problem — Worst Imaginable

Please note the severity of your problem within the last week:

No Problem — Worst Imaginable

Comments (please mention any other problems you would like to discuss):

____

____

____

____

Indicate painful or distressed areas: