Acupuncture House Calls of Dallas

Kim Blankenship, L.Ac.

Today's Date: ____/____/____

Name: _____

Address: _____

City/State/Zip _____

Cell Phone: _____ Work _____ Home _____

Email: _____

Contact Person: Name/Relationship:_____

Cell Phone: _____

Occupation: _____

How did you hear about us? _____

****

Birth date: ____/____/____ Age: _____

Gender Identity (optional) ___ Male ___ Female ___ Transgender ___ Other _____

What are your primary reasons for seeking treatment?

1). _____

2). _____

3). _____

List all medications and/or supplements you are taking: _____

_____

List serious illnesses, accidents or surgeries: _____

_____

Check illnesses that have occurred in blood relatives: ___ High Blood Pressure ___ Stroke

___ Diabetes ___ Cancer ___ Heart Disease ___ Kidney Disease

Check conditions you have or have had in the past: ___ Diabetes ___ Cancer ___ AIDS

___ Allergies ___ Bleeding disorders ___ Breast lump ___Arthritis ___Anemia

___Hepatitis (Type ____)

Please check symptoms that you currently have or have had in the past year:

MUSCLES/JOINTS/BONES

___ Tremors or cramps
___ Swollen joints
Pain, weakness, numbness in:
___ Arms or hips
___ Back or legs
___ Feet
___ Neck
___ Hands
___ Shoulders
___ Other _____

EYES/EARS/NOSE/THROAT/ RESPIRATORY

___ Asthma/wheezing
___ Difficulty breathing
___ Frequent colds
___ Hay fever
___ Sinus problems
___ Nosebleeds
___ Persistent cough
___ Hoarseness
___ Enlarged glands
___ Gum problems
___ Eye pain
___ Blurred or failing vision
___ Ringing in ears
___ Loss of hearing
___ Earache

SKIN

___ Bruise easily
___ Dry skin
___ Sores won't heal
___ Itching/rashes
___ Boils
___ Sweats
___ Sensitive skin

GENITO/URINARY

___ Frequent urination
___ Inability to control urine
___ Blood/pus in urine
___ Kidney infections/stones
___ Low libido

CARDIOVASCULAR

___ High or low blood pressure (circle)
___ Poor circulation
___ Chest pain
___ Hardening of arteries
___ Rapid/irregular heart beat
___ Previous heart attack
___ Ankle swelling

GASTROINTESTINAL

___ Nausea
___ Indigestion
___ Vomiting
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Excessive/poor appetite (circle)
___ Belching, gas or bloating
___ Difficulty swallowing
___ Gall bladder problems
___ Stomach pain

IF APPLICABLE:

___ Erection difficulties
___ Prostate problems
___ Penile discharge
___ Irregular menstrual cycle
___ Excessive/scanty menstrual flow(circle)
___ Extreme menstrual pain
___ Bleeding between periods
___ Clots
___ PMS
___ Previous miscarriage
___ Menopause symptoms
Could you be pregnant? _____

___ Depression
___ Excessive worry/anger/fear
___ Fatigue/tiredness
___ Loss of sleep/poor sleep
___ Nervousness/irritability
___ Weight loss/gain
___ Dizziness
___ Headaches
___ Difficulty in focusing/concentrating
___ Easily startled
___ Overwhelmed by life

Signature_____ Date _____