



North Star Acupuncture

Deborah Meuse, Licensed Acupuncturist

Name _____ Date of Birth: _____
Address: _____
City, State, Zip: _____
Telephone: Home: _____ Work: _____
Cell: _____ Email address: _____
Occupation: _____
Primary Care Physician: _____
Emergency Contact: _____ Telephone : _____
How did you hear about my office? _____

What is the main problem you would like to address with acupuncture?

How long ago did this problem begin? Please be specific if you can.

How does this problem interfere with your daily activities or lifestyle?

What other treatments or solutions have you tried?

Has your primary care physician given you a Western Medical diagnosis?

Please list any medications you are currently taking and what they are for.

Please list any vitamins, herbs or supplements you are taking for this or other conditions.

Please check off each symptom you have experienced in the past six months:

Head/Face

- Migraines
- Frequent headaches
- Dizzy, fainting
- Poor memory
- Head feels cloudy/heavy
- Facial paralysis

Eyes

- Blurring of vision
- Floaters
- Watery eyes
- Dry eyes
- Itchy, irritated eyes
- Loss of vision

Ears

- Ringing in ears
- Loss of hearing
- Ear Infections
- Congestion
- Dizziness: vertigo

Nose/Throat

- Allergies
- Sinus infections
- Sinus headaches
- Trouble swallowing
- Sensation of "lump in throat"
- Chronic laryngitis

Skin/Hair

- Psoriasis
- Eczema
- Hives
- Other rash
- Dryness
- Recent thinning hair

Body Temperature

- Always cold
- Always hot
- Cold hands & feet
- Sweating at night
- Sweating too much
- Sweating too little

Respiratory

- Shortness of breath
- Asthma
- Chronic bronchitis
- Cough
- Emphysema
- Lung cancer
- Heaviness in chest

Cardiovascular

- Pain in chest
- Tightness in chest
- Heart palpitations
- Irregular heart rhythm
- High blood pressure
- High cholesterol
- Hardening of arteries

Energy Level

- Fatigue
- Heavy Limbs
- Feeling sleepy
- Difficulty walking
- Too much energy
- Restlessness
- Waking up tired

Appetite/Thirst

- Increased appetite
- Decreased appetite
- Crave sweet taste
- Crave sour taste
- Crave salty taste
- Crave bitter taste
- Crave pungent taste
- Excess thirst
- Lack of thirst

Digestion

- Heartburn
- Chronic gas
- Nausea
- Vomiting
- Abdominal pain
- Cramping
- Gall stones
- Food allergies

Stools

- Diarrhea
- Constipation
- Irritable bowel
- Blood in stool
- Mucus in stool
- Colitis
- Hemorrhoids
- Parasites

Urination

- Increased frequency
- Pain or burning
- Waking to urinate at night
- Incontinence/leaking
- Difficulty urinating
- Frequent infections
- Kidney stones

Muscles & Joints

- Arthritis in _____
- Bursitis in _____
- Tendonitis in _____
- Twitching muscles
- Stiff/tight muscles
- Sciatica/low back pain
- Neck pain

Sleep

- Hard to fall asleep
- Hard to stay asleep
- Nightmares
- Snoring
- "Restless legs"

OB/GYN

- Irregular periods
- Heavy periods
- Light periods
- PMS
- Cramping
- Endometriosis
- Ovarian Cysts
- Uterine fibroids
- Sexually transmitted disease

Fertility

- Miscarriage
- Stillbirth
- # Pregnancies
- # Children
- # Abortions
- Irregular ovulation
- Other information

Other symptoms

Mental Health

- Anxiety
- Bipolar disorder
- Seasonal affective disorder

- Panic attacks
- Phobias

- Depression
- Other

Please rate the degree to which the following emotions are problematic for you:

- | | | | |
|--|------------|-----------|------------|
| <input type="checkbox"/> Grief & Sadness | Not at all | Sometimes | Frequently |
| <input type="checkbox"/> Excitement & Mania | Not at all | Sometimes | Frequently |
| <input type="checkbox"/> Anger & Frustration | Not at all | Sometimes | Frequently |
| <input type="checkbox"/> Fear & Dread | Not at all | Sometimes | Frequently |
| <input type="checkbox"/> Worry & Excess thinking | Not at all | Sometimes | Frequently |

Family History: Is there anyone in your immediate family with:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Other inherited conditions _____ | | |

Please list history of surgeries, hospitalizations and other medical conditions:

Lifestyle questions:

- How much coffee, tea, or cola do you drink per week? _____
- How much alcohol do you drink per week? _____
- How many packs of cigarettes do you smoke per week? _____
- Do you have a regular exercise program? _____

Are there additional problems you hope to discuss with me or address with acupuncture?
