Erika Eddy L.Ac., MSAOM
317 Main Street
Templeton, CA 93465
www.ErikaEddy.com
805-215-3942

Today's Date:________________(PLEASE PRINT LEGIBLY)

_______________________________________ M / F _______________________

Last name First name M.I. Sex Birthdate Age

____

Address City State Zip

(______)_____________________(______)____________________________________

Phone Cell Email

Referred by:____

Have you ever had acupuncture? **Yes / No**

Present health concerns (please include diagnosis if applicable):

____

____

What makes present concern better?

____

____

What makes it worse?

____

____

Please tell me about any previous treatments you have tried for your condition (Acupuncture, Homeopathy, Massage, Nutrition, M.D., etc.) and the results:

____

____

Name of primary health care provider and others on your health team (M.D., Chiropractor, etc.)

____

____

Are you currently under the care of this health care provider? **Yes / No**

Are you currently taking any prescribed medications? If so, please list:

____

____

Are you currently taking any vitamins, supplements, or herbs? If so, please list:

____

____

Last blood work taken: ____

Please rate your general energy level on scale of 1-10: 1 = exhausted & 10 = great: _____

What time of day do you feel best? ________________ Worst? _____________

Hobbies / Interests:

____

____

What are your **most commonly experienced** emotions? Please 'X'
Anger_____ Frustration_____ Worry_____ Sadness_____ Fear_____
Excitement_____ Joy_____

What emotions do you have a **difficult** time expressing? Please 'X'
Anger_____ Frustration_____ Worry_____ Sadness_____ Fear_____
Excitement_____ Joy_____

PAST HISTORY OF:

Adult/Childhood Illness:

____

____

Surgeries:

____

____

WOMEN

Age of first period:________________Last pap:___________________Results:_________

Length of full monthly cycle:________days Duration of flow:_________________days

Is cycle regular? **Yes / No**

Any spotting? **Yes / No** Pain? **Yes / No** PMS? **Yes / No**

Vaginal discharge? **Yes / No** Other?_______

Pregnant? **Yes / No** Children? **Yes / No** Ages?_________ Birth control?

Yes / No If yes, type?______

MEN

History of impotence, premature ejaculation, fertility difficulties, discharge from penis, vasectomy, etc.

____

____

STDs (herpes, warts, etc.)?____

Children? **Yes / No** Ages?__________

Which of the following make you feel **bad/worse**? Please 'X'

Cold_____ Heat_____ Damp_____ Dry_____ Wind_____ Humidity_____

Fog_____

Which of the following make you feel **good/better**? Please 'X'

Cold_____ Heat_____ Damp_____ Dry_____ Wind_____ Humidity_____

Fog_____

DIET

How much of each of the following do you consume daily?

Recreational drugs, smoking (i.e. marijuana):______________________________________

Artificial Sweeteners:____

Coffee / tea / caffeinated beverages:____

Water: ____

Dairy products (milk, cheese, butter, yogurt, ice cream, etc.):________________________

____

Meat / fish / poultry:____

Breads / grains:____

Cooked vegetables:____

Raw fruits / raw vegetables:____

Specific food / flavor cravings:____

Exercise (type, duration, number of times per week): _______________________________

____

PLEASE "X" ALL THAT APPLY:

General

( ) Bruise Easily
( ) Sweat Easily
( ) Night Sweats
( ) Spontaneous Day Sweat
( ) Always Cold
( ) Always Hot
( )Better with Cold
( ) Better with Heat
( ) Chills
( ) Feverish at Night
( ) Feverish During Day
( ) Heaviness of Body
( ) Heaviness of Limbs
( ) Hot Palms/ Soles
( ) Memory Loss
( ) Poor Memory
( ) Forgetfulness
( ) Always Thirsty
( ) Thirsty for Hot
( ) Thirsty for Cold
( ) No Thirst
( ) Weight Gain
( ) Weight Loss

Cardiovascular

( ) Blood Clots
( ) Chest Pain
( ) Cold Hands/ Feet
( ) Easily Fatigued
( ) Fainting
( ) Fullness
( ) High Blood Pressure
( ) Irregular Heart Beat
( ) Low Blood Pressure
( ) Palpitations
( ) Phlebitis
( ) Swelling of Hands/ Feet

Ears

( ) Decreased hearing
( ) Infection
( ) Ringing- High pitch
( ) Ringing- Low pitch

Eyes

( ) Blurred Vision
( ) Cataracts
( ) Dry Eyes
( ) Eye Inflammation
( ) Glasses/ Contacts
( ) Poor Night Vision
( ) Poor Vision
( ) Red/Painful
( ) Redness/ Dryness
( ) Spots/Floaters
( ) Visual Changes
( ) Blurry Vision
( ) Excessive Tearing
( ) Floaters

Gastro-Intestinal

( ) Bad Breath
( ) Belching
( ) Burning Rectum/Anus
( ) Constipation
( ) Diarrhea - Acute
( ) Diarrhea - Chronic
( ) Excessive Appetite
( ) Poor Appetite
( ) Gall Bladder Disorder
( ) Stool – Blood
( ) Stool - Burning
( ) Stool - Difficult
( ) Stool - Dry
( ) Stool - Loose
( ) Stool – Undigested food
( ) Gas
( ) Hemorrhoids
( ) Hernia – Inguinal/Umbillical
( ) Indigestion
( ) Nausea
( ) Pain or Cramps
( ) Rectal Pain
( ) Vomiting

Genito-Urinary

( ) Blood in Urine
( ) Frequent Urination
( ) Kidney Stones
( ) Pain or Urination
( ) Unable to Hold Urine
( ) Urgency to Urinate

Head & Neck

( ) Concussions
( ) Dizziness
( ) Enlarged Lymph Glands
( ) Fainting
( ) Headaches
( ) Migraine
( ) Neck Stiffness

Infection Screening

( ) Chlamydia
( ) Genital Warts
( ) Gonorrhea
( ) Hepatitis
( ) Hepatitis A/B/C
( ) Herpes: Genital
( ) Herpes: Oral
( ) HIV
( ) Syphilis
( ) TB

Musculo-Skeletal

( ) Upper Back Pain
( ) Joint Pain
( ) Low Back Pain
( ) Muscle Spasm, Twitching, Cramps
( ) Sore, Cold or Weak Knees
( ) Stiff Neck/ Shoulders
( ) Weather Sensitivity

Neurological

( ) Concussion
( ) Numbness/ Tingling of Limbs
( ) Pain
( ) Paralysis
( ) Seizures
( ) Tremors
( ) Numbness: Where?__________
( ) Poor Coordination

Nose, Throat & Mouth

( ) Catch Cold Easily
( ) Dry Nose

( ) Hay Fever or Allergies
( ) Nose Bleeds
( ) Sinus Infections
( ) Discharge: Color?

____
( ) Chronic Hoarseness
( ) Coughing Mucus: Color?

____
( ) Difficulty Swallowing
( ) Recurring Sore Throats
( ) TMJ
( ) Voice:Hard to Project?
( ) Grinding Teeth
( ) Sores on Gums
( ) Sores on Lips
( ) Sores on Tongue
( ) Tooth Loss
( ) Bleeding Gums

Psychological
( ) Anxiety/Stress
( ) Depression
( ) Irritability
( ) Easily Startled
( ) Fear
( ) Grief/Sadness
( ) Hysteria
( ) Indecisiveness
( ) Irritable
( ) Can't "Stop Going"

Respiratory
( ) Asthma
( ) Bronchitis
( ) Difficult to Inhale
( ) Difficulty Breathing
( ) Shortness of Breath
( ) Wheezing
( ) Frequent Colds
( ) Chronic Obstructive
( ) Pneumonia
( ) Cough
( ) Coughing Blood
( ) Production of Phlegm
( ) Clearing Throat Often

Skin, Hair & Nails
( ) Dryness
( ) Eczema
( ) Hives
( ) Itching
( ) Pimples
( ) Psoriasis
( ) Rashes
( ) Tumors, Lumps
( ) Dry/Dull Hair
( ) Hair Loss
( ) Premature Gray Hair
( ) Brittle Nails
( ) Painful Gums

I agree that the above information is accurate and true to my knowledge.

____

Signature of patient **Date**