The Turning Point: A Community Acupuncture Center, 243 W. Patrick Street, Frederick MD 21701 (240) 405-7878

Name: ____ DOB: ____________________

Please place a check next to any condition you are currently experiencing:

General
___Loss of Sleep / Poor Sleep
___Fatigue
___Frequent Thirst
___Daytime / Nighttime Sweating
___Depression
___Anxiety / Worry
___Irritability / Anger
___Overwhelmed by Life
___Fear
___Nervousness

Muscles and Joints
___Tremors
___Swollen Joints
___Muscle Cramps
___Headaches / Migraines
___Knee Pain
___Back Pain
___Neck Pain
___Pain Anywhere Else

Eyes
___Blurred Vision
___Glasses/Contacts
___Floaters

Ears, Nose, and Throat
___Ringing in Ear / Tinnitus
___Diminished Hearing / Deaf
___Chronic Sinus Infections
___Mouth / Tongue Sores
___Bleeding Gums
___TMJ
___Runny Nose
___Nose Bleeds
___Excessive Phlegm
___Ear Ache
___Eye Pain

Skin
___Itching
___Hives
___Acne
___Eczema / Psoriasis
___Bruise Easily

Respiratory
___Chronic Cough
___Wheezing / Asthma
___Shortness of Breath
___Frequent Colds
___Hay Fever / Allergies

Cardiovascular
___High / Low Blood Pressure
___Rapid Irregular Heartbeat
___Chest Pain or Tightness
___Cold Hands / Cold Feet

Gastrointestinal
___Bad Breath
___Poor Appetite
___Excessive Hunger/Cravings
___Recent Weight Gain /Loss
___Nausea / Vomiting
___Reflux / Acid Regurgitation
___Gas / Bloating / Belching
___Loose Stools / Diarrhea
___Constipation
___Hemorrhoids
___Bloody or Black Stools
___Stomach/Intestines Pain
___Indigestion

Genito-urinary
___Pain on Urination
___Frequent Urination
___Blood in Urine
___Dribbling Urine
___Wake to Urinate

Neurological
___Seizures
___Dizziness / Loss of Balance
___Poor Concentration

Tobacco, Food, Drink Habits
___Currently Smoke / Use Tobacco
___History Smoked/Used Tobacco
___Recreational Drug Use
___Drink Alcohol
How much/often? ____________

Reproductive
___Pregnant or Possibly Pregnant
___Vaginal Infections
___Pain / Itching of Genitalia
___Pelvic Inflammatory Disease
___Very Light/Spotty Bleeding
___Menopausal Symptoms:
 ___Hot Flashes
 ___Night Sweats
 ___Age at Onset of Menopause
___Breast Lumps
___Clotting During Menses
___Number of Live Births:
Children's Ages: ____________
___History of Miscarriages
___Irregular Menstrual Periods
___Painful Menstrual Periods
___Premenstrual Syndrome (PMS)
___Excessive Bleeding
___Bleeding Between Periods
___Libido: Is there anything you'd like to address? ______________
___Prostate Trouble
___Erectile Difficulties
___Penis Discharge

Psychological
___Considered/Attempted Suicide
___Seeing a Therapist

Other
___HIV / AIDS
___Hepatitis
___Infectious Diseases
___Diabetes
___Metal Joints/Implants?
___History of Cancer
___Undergoing Cancer Treatments
___Autoimmune Disorder:
____
___Hypothyroid
___Hyperthyroid
Other: ____________________

Is there anything you'd like to discuss regarding Lifestyle, Exercise or Diet? ______________________________

Anything else you wish to discuss? ____

Please list any current prescription medications, herbs, supplements, hospitalizations, & traumas on the back.