BEACH
ACUPUNCTURE
by Andrea Hutter, LAc

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BEACHACUPUNCTURE.NET

GENERAL INFORMATION

LAST	FIRST	MIDDLE
PATIENT FULL NAME		

DIRECTION/STREET	CITY	STATE	ZIP
ADDRESS			

HOME PHONE	**WORK PHONE**	**MOBILE PHONE**

EMAIL ADDRESS	**AGE**	**GENDER**	**MARITAL STATUS**

DATE OF BIRTH	**SOCIAL SECURITY NUMBER**
REFERRED BY	

EMERGENCY CONTACT

NAME	**RELATIONSHIP**	**TELEPHONE**

IF MINOR PARENT/GUARDIAN NAME	**NAME**	**RELATIONSHIP**	**TELEPHONE**
	NAME	**RELATIONSHIP**	**TELEPHONE**

CASE HISTORY

CHIEF COMPLAINTS
1
2
3

PAIN SCALE CIRCLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	MINOR DISCOMFORT									MAJOR DISCOMFORT

PERSONAL INJURY	WORK INJURY	VEHICLE COLLISION	OTHER	EXPLAIN
PAIN RESULTING FROM				

	YES	NO	
DATE PAIN FIRST BEGAN	**HAVE YOU SEEN A DOCTOR REGARDING THIS CONDITION?**		IF SO WHEN

DOCTOR NAME	**TELEPHONE NUMBER**

HAVE YOU RECENTLY HAD X-RAYS PERFORMED?	**IF SO WHEN**	**AREA(S) X-RAYED**

ARE YOU PREGNANT	**IF YES WHAT MONTH**

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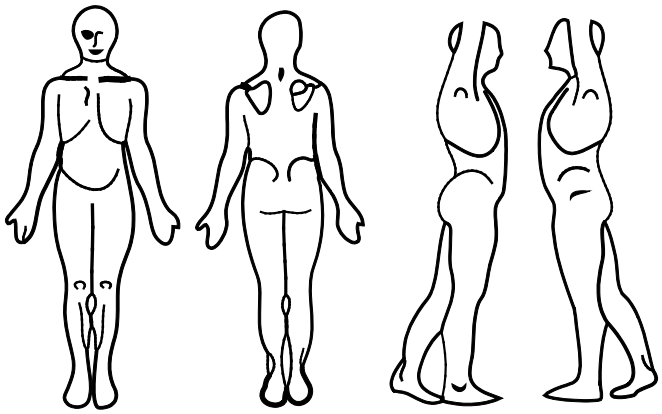
PAIN PROFILE

PLEASE MARK ANY AREAS OF PAIN



	IS THE PAIN…				
	SHARP		ACHING		CRAMPING
	DULL		MOVING		TINGLING
	BURNING		OTHER		
	DO THE FOLLOWING LESSEN THE PAIN?				
	PRESSURE		HEAT		COLD
	EXERCISE		REST		
	DO THE FOLLOWING WORSEN THE PAIN?				
	PRESSURE		HEAT		COLD
	EXERCISE		REST		
	OTHER				

PAIN PROFILE

REASON	**WHEN**

PLEASE DESCRIBE ANY TRAUMA (EMOTION OR PHYSICAL)

RECENT TESTS

	BLOOD		PAP SMEAR		MAMMOGRAM		PELVIC EXAM
	CHOLESTEROL		PROSTATE/PSA		STD		HIV
	THYROID/TSH		BONE DENSITY		CLINIC SKIN EXAM		FASTING PLASMA GLUCOSE (DIABETES)

OTHER

RESULTS AND DATE

DATE OF LAST PHYSICAL EXAMINATION

NAME OF PHYSICIAN	**TELEPHONE**

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MEDICATIONS

LIST ANY PRESCRIPTION DRUGS OR SUPPLEMENTS YOU ARE TAKING

DRUG/SUPPLEMENT	DOSE	FREQUENCY	FOR WHAT CONDITION

EATING HABITS PROFILE

MEAL PERIOD	TIME OF MEAL	LIST ALL FOODS COMMONLY ASSOCIATED WITH THIS MEAL PERIOD	CONSUMED OFTEN?	
BREAKFAST			Y	N
LUNCH			Y	N
DINNER			Y	N
LIST SNACKS			Y	N

WHAT DO YOU HOPE TO ACCOMPLISH DURING THIS TREATMENT?

CASE HISTORY

NOTE ANY CONDITIONS YOU HAVE HAD/CURRENTLY HAVE IN THE APPROPRIATE BOXES BELOW

PAST	CURRENTLY	CONDITION	PAST	CURRENTLY	CONDITION
		RESPIRATORY			**CARDIOVASCULAR**
		ALLERGIES			PALPITATIONS
		ASTHMA/DIFFICULTY WITH EXHALE			ANXIETY
		SHORTNESS OF BREATH			PANIC ATTACKS
		HOARSE VOICE			CHEST PAIN/DISCOMFORT
		DRY COUGH			RESTLESSNESS/AGITATION
		PRODUCTIVE COUGH COLOR OF DISCHARGE: _____			EASILY STARTLED
		SADNESS OR GRIEF			FREQUENT/VIVID DREAMS
		DISLIKE TALKING			FAINTING
		NOSE BLEEDS			EMOTIONAL HYPERSENSITIVITY
		NASAL DISCHARGE			TONGUE SORES
		POST NASAL DRIP			EXCESS SWEATING ON CHEST
		FREQUENTLY CATCH COLDS			WAKE UP EARLY UNABLE TO SLEEP
		SORE THROAT			SWOLLEN ANKLES
		DRYNESS OF NOSE / THROAT / MOUTH (CIRCLE ANY/ALL)			POOR CIRCULATION

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CASE HISTORY — CONTINUED

NOTE ANY CONDITIONS YOU HAVE HAD/CURRENTLY HAVE IN THE APPROPRIATE BOXES BELOW

PAST	CURRENTLY	CONDITION	PAST	CURRENTLY	CONDITION
		MENTAL			**KIDNEY & BLADDER**
		LOW APPETITE			LOW BACK PAIN
		BLOATING			SORE, COLD OR WEEK KNEES
		FATIGUE AFTER EATING			FREQUENT CAVITIES
		LOOSE STOOL			HAIR LOSS OR PREMATURE GRAYING
		SUDDEN WEIGHT LOSS/GAIN			HEARING LOSS OR DIFFICULTY
		BRUISE EASILY			RINGING IN EARS – LOW PITCH / OCEAN
		HEMORRHOIDS			KIDNEY STONES
		COLD HANDS & FEET			BONE OR JOINT PROBLEMS
		DIGESTIVE PROBLEMS			NIGHT-TIME URINATION
		VARICOSE VEINS			FEAR OR PHOBIA
		WORRY			DARK CIRCLES UNDER EYES
		OVERWHELMED EASILY			MEMORY DIFFICULTY
		DIFFICULTY FOCUSING			ASTHMA-DIFFICULTY WITH INHALE
		STOMACH PAIN			LOW LIBIDO
		MOUTH SORES			PROLONGED RECOVERY FROM ILLNESS
		BELCHING			DECREASED MOTIVATION
		HICCOUGHS			URGENT URINATION
		NAUSEA & VOMITING			URINARY TRACT INFECTION (UTI)
		BULIMIA			DIFFICULT OR INCOMPLETE URINATION
		ANOREXIA			LOSS OF BLADDER CONTROL
		BURNING SENSATION AFTER EATING			
		HEADACHE OVER FOREHEAD REGION			**TEMPERATURE (KIDNEY FUNCTION)**
		DIFFICULTY FALLING ASLEEP			NIGHT SWEATS
		ULCER (PREVIOUSLY DIAGNOSED)			HEAT SENSATION IN PALMS, FEET & CHEST
		BAD BREATH			BURNING SENSATION ON SOLES OF FEET
		BLEEDING SWOLLEN OR PAINFUL GUMS			HOT FLASHES ANY TIME
		HEARTBURN, ACID REGURGITATION, GERD			BODY TEMP HOT
		LARGE APPETITE			BODY TEMP COLD
					THIRSTY
		NEUROLOGICAL FUNCTION			**DAMPNESS**
		STROKE			SWOLLEN HANDS AND FEET
		NUMBNESS OR TINGLING			GENERAL SENSATION OF HEAVINESS
		MIGRAINES			TIRED AND SLUGGISH AFTER A MEAL
		SEIZURES OR TREMORS			SNORING
		EPILEPSY OR CONVULSIONS			SINUS CONGESTION
					PUSTULAR ACNE
		BLOOD (LIVER, SPLEEN, HEART FUNCTION)			MENTAL FOGGINESS
		ANEMIA			SLUGGISH
		DRY SKIN OR HAIR			
		BRITTLE NAILS			**MEN ONLY**
		RESTLESS SLEEP			PREMATURE EJACULATION
		DRY MUCOUS MEMBRANES			SWOLLEN TESTICLES
		MUSCLE CRAMPING			TESTICULAR PAIN
		FATIGUE WITH RESTLESSNESS			COLD FEELING IN GENITALS
		DRY HARD STOOL			PROSTATITIS
		POOR SKIN HEALING			ELEVATED PSA
		NUMBNESS IN HANDS OR FEET, WORSE AT NIGHT			ABNORMAL SPERM
		VARICOSE OR SPIDER VEINS			IMPOTENCE
		FLOATERS IN EYES			GENITAL DISCHARGE
		DIZZINESS OR LIGHT HEADED			**LIST ANY OTHER ITEMS BELOW**
		THINNING HAIR ON HEAD (OVERALL, NOT PATCHES)			

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WOMEN ONLY					GYNECOLOGY
	YES	NO			
ARE YOU CURRENTLY PREGNANT?			AGE OF FIRST MENSES?		
COULD YOU POSSIBLY BE PREGNANT?			HOW MANY DAYS DO YOU BLEED?		
			DATE OF LAST MENSTRUAL PERIOD:		
NUMBER OF DAYS OF ENTIRE CYCLE FROM DAY 1 (DAY YOU START BLEEDING) UNTIL NEXT DAY 1?					
HOW HEAVY IS THE BLEEDING? (CIRCLE)	LIGHT	MEDIUM	HEAVY		
COLOR OF MENSTRUAL BLOOD (CIRCLE)	LIGHT RED	RED	DARK RED	BROWN	PURPLE

DO YOU EXPERIENCE ANY OF THE FOLLOWING

	PRE MENSTRUAL TENSION		PREMENSTRUAL ACNE		BLOOD CLOTS W/MENSES
	BREASTS DISTENTION AND PAIN		ABNORMAL BLEEDING		YEAST INFECTION OR VAGINAL ITCHING
	MENSTRUAL CRAMPS		VAGINAL DRYNESS		PROFUSE VAGINAL DISCHARGE
	SPOTTING BEFORE ONSET OF MENSES		FIBROCYSTIC BREASTS		PREMENSTRUAL LOWER BACK PAIN
	VAGINAL ITCHING OR IRRITATION		SHORT CYCLE		NIPPLE PAIN OR DISCHARGE

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING

	UTERINE FIBROIDS		ENDOMETRIOSIS		POLYCYSTIC OVARIES
	UTERINE POLYPS		PELVIC ADHESIONS		PELVIC ABNORMALITIES

OTHER

CURRENT METHOD OF CONTRACEPTION	**PAST METHOD**