

Marie Yuann, LAc
Yuann Acupuncture
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Name _____ Sex: M / F DOB: ___/___/___
Address: _____ Apt. # _____
City _____ State _____ Zip _____
Phone (H) _____ (W) _____ Email _____
Occupation _____ Referred by _____

I. What is your main complaint:

Please "Yes" when applicable, put a check mark, or fill in the blanks below:

II. Are you troubled by the following symptoms?

- | | | | | | |
|------------------------|-----|--------------------------|-----|-----------------------------|-----|
| 1. Fatigue | yes | 10. Loss of Appetite | yes | 19. Depression | yes |
| 2. Dizziness | yes | 11. Abdominal Distension | yes | 20. Anxiety | yes |
| 3. Palpitations | yes | 12. Headache | yes | 21. Nervousness | yes |
| 4. Hot Flashes | yes | 13. Stomachache | yes | 22. Angry Mood | yes |
| 5. Perspire a lot | yes | 14. Diarrhea | yes | 23. Nightmares | yes |
| 6. Shortness of Breath | yes | 15. Constipation | yes | 24. Loss of Sexual Interest | yes |
| 7. Chest Pain | yes | 16. Skin Rash | yes | 25. Forgetting Information | yes |
| 8. Back Pain | yes | 17. Dry Mouth | yes | 26. Frequent Urination | yes |
| 9. Muscle Tension | yes | 18. Insomnia | yes | 27. Cold Hands & Feet | yes |

II. Do you have or have you had the following?

- | | | | | | |
|-------------------------|------------------|------------------|------------|--------------------|-----------|
| 1. Heart Disease: | ___ heart attack | ___ arrhythmia | ___ angina | medications: _____ | |
| 2. Allergies: | ___ wheat | ___ nuts | ___ fruit | ___ seafood | ___ dairy |
| | ___ pollen | ___ fall | ___ spring | ___ all year | |
| 3. High Blood Pressure: | ___ how long | ___ special diet | | medications: _____ | |
| 4. Diabetes: | ___ how long | ___ special diet | | medications: _____ | |
| 5. High Cholesterol: | ___ how long | ___ special diet | | medications: _____ | |
| 6. Organs removed: | ___ which ones | | | when _____ | |

III. For women only

- Menstrual Cramps: ___ none ___ before ___ during ___ after
Pain Intensity (10 being the worst): 1 2 3 4 5 6 7 8 9 10
Menstrual Disorders: ___ early ___ late ___ irregular ___ short cycle ___ long cycle
Other Symptoms: ___ diarrhea ___ constipation ___ headache ___ bloating
Vaginal Discharge: ___ none ___ white ___ yellow ___ heavy
Flow (quantity): ___ light ___ heavy ___ # days of flow ___ clots
Are you pregnant? ___ no ___ yes ___ which month

IV. Any other medical problems? _____

Signature _____ Date _____

(For Office Use Only)

Diagnosis: MEN _____ ST _____ GB _____ UB _____ INJ _____
 PMS _____ SP _____ LU _____ BC _____ TE _____
 H _____ LIV _____ K _____ UC _____ FS _____