B O D Y S C A P E S

Patient Form Date: _____

Please complete this form as thoroughly as possible. All information you provide is pertinent to the proper diagnosis and treatment of your medical condition. All information provided is kept confidential.

General Information

Name (first): _____ (last): _____Date-of-Birth: _____

Street Address: _____City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address (please print clearly): _____

Emergency Contact (name): _____ Phone Number: _____

Primary Physician: _____Phone Number: _____

How did you hear about Bodyscapes? □ Internet □ Doctor Referral □ Ad □ Event □ Word-of-Mouth

Primary Health Concerns

Please list the primary and secondary (if applicable) health condition you would like to be treated for:

Primary: _____Secondary: _____

Onset of condition: _____ Cause (if known): _____

Has this condition been diagnosed by a physician? (please circle) Yes No

Are you currently under the care of a physician for this condition? (please circle) Yes No

Are there any therapies you are currently undergoing for this condition? (please circle) Yes No

If yes, please list: _____

What makes it worse? _____

What makes it better? _____

Does your condition interfere with any of the following?

□ Work	□ Sitting	□ Stretching	□ Sexual	□ Other
□ Sleep	□ Standing	□ Recreation	□ Social life	_____
□ Walking	□ Bending	□ Relationship	□ Emotions	

Have you ever had Acupuncture or Oriental Medicine before? (please circle) Yes No

Are you interested in:

□ Pain relief	□ Oriental nutrition	□ Maintenance care	□ Stress relief
□ Preventative care	□ Herbal therapy	□ Performance care	□ Other _____

What are your health goals? _____

_____

Medical History

How was your childhood health? _____

Any past or future surgeries? (include dates) _____

Any significant trauma? (auto accidents, falls, emotional, sexual) _____

Do you have any allergies? Yes No If yes, please list: _____

Do you take any medications (include over-the-counter)?

Name of medication	Reason for taking it
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Are you interested in getting off any of your medication? _____
Please list any supplements you are taking: _____

Have you had any long-term or frequent use of antibiotics? Yes No Describe: _____

Have you ever had or currently suffer from any of the following conditions? ___

□ Acne
□ Acid reflux
□ Allergies
□ Anemia
□ Asthma
□ Athlete's foot
□ Autoimmune
□ Blood transfusion
□ Bone spurs
□ Bone fractures
□ Bronchitis
□ Bulging disc
□ Bursitis
□ Cancer
□ Candidiasis
□ Carpal tunnel
□ Colitis
□ COPD
□ Crohn's disease
□ Dementia
□ Degenerating disc
□ Depression
□ Diabetes
□ Drug reaction
□ Eating disorder
□ Eczema
□ Epilepsy
□ Fibromyalgia
□ Frequent colds
□ Fungal infection
□ GERD
□ Gout
□ Heart attack
□ Heart disease
□ Hemorrhoids
□ Hepatitis
□ High blood pressure
□ HIV/Aids
□ Hyper thyroid
□ Hypo thyroid
□ IBS
□ Infertility
□ Jaundice
□ Joint swelling
□ Kidney stones
□ Lots of cavities
□ Low blood pressure
□ Measles
□ Meniere's disease
□ Mental breakdown
□ Mental illness
□ Migraine
□ Multiple sclerosis
□ Mumps
□ Neuropathy
□ Obesity
□ Osteoarthritis
□ Osteopenia
□ Osteoporosis
□ Parasites
□ Plantar fasciitis
□ Pneumonia
□ Premature graying
□ Psoriasis
□ Rash
□ Rheumatoid arthritis
□ Scoliosis
□ Seizures
□ Skin conditions
□ Spinal stenosis
□ Spondylolisthesis
□ STD
□ Teeth grinding
□ Tendonitis
□ Tension headache
□ Tinnitus
□ TMJ dysfunction
□ Tuberculosis
□ Ulcer
□ Vertigo

Please list any other conditions I should be aware of:

_____

Symptoms

Please check ALL symptoms you currently have. Be as specific as possible.

Qi Deficiency/Stagnation ___

□ Fatigue
□ General weakness
□ Low voice
□ Shortness of breath
□ Spontaneous sweating
□ Shallow breathing
□ Laziness to speak
□ Local pain
□ Abdominal distention
□ Feeling of oppression
□ Distending pain
□ Painful swollen breasts
□ Rectal pressure

Counterflow Qi ___

□ Cough □ Nausea □ Vomit □ Hiccough □ Dizziness

Blood Deficiency/Stagnation/Heat ___

□ Pale complexion
□ Lusterless complexion
□ Pale lips
□ Dry skin
□ Dry, brittle nails
□ Lifeless hair
□ Hair loss
□ Dizziness
□ Blurry vision
□ Palpitations
□ Insomnia
□ Numbness in extremities
□ Stiffness
□ Dark facial complexion
□ Painful, hard swellings
□ Swollen glands
□ Stabbing pain in fixed location
□ Bruise easily
□ Excess menstrual bleeding
□ Frequent nose bleeds
□ Blood in stools
□ Blood in urine

Lungs ___

□ Grief
□ Sadness
□ Weak breathing
□ Shortness of breath on exertion
□ Weak cough
□ Thin watery sputum
□ Weak voice
□ Spontaneous sweating
□ Daytime sweating
□ Aversion to Cold
□ Weakened immunity
□ Frequent colds
□ Ear ache
□ Dry cough
□ Cough with sticky sputum
□ Difficult to expectorate
□ Dry mouth and throat
□ Hoarse voice
□ Low grade fever
□ Night sweats
□ Heat in palms, soles and chest
□ Blood tinged sputum
□ Insomnia
□ Thirst
□ Fever
□ Occipital headache
□ Whole head headache
□ Body aches
□ Sneezing
□ Stuffy nose
□ Runny nose with thin clear mucus
□ Itching throat
□ Profuse white phlegm that is easily expectorated
□ Chronic cough
□ Acute attacks
□ Stuffiness in the chest
□ Symptoms worse lying down
□ Yellow or green mucus
□ Foul smelling mucus
□ Sinus infection
□ Asthma
□ Cough with frothy white and watery sputum
□ Chills
□ Vomiting of frothy sputum

Large Intestine ___

□ Abdominal pain
□ Diarrhea
□ Mucus and blood in the stool
□ Foul stool, burning anus
□ Scanty and dark urine
□ Fever and sweating
□ Thirst without a desire to drink
□ Heavy sensation in the body and limbs
□ Stuffiness in the chest and epigastrium
□ Constipation with dry stools
□ Burning sensation in mouth
□ Burning sensation in anus
□ Scanty and dark urine
□ Dry stools that are hard to pass
□ Dry mouth and throat
□ Loose stools
□ Dull abdominal pain
□ Borborygmus (stomach rumbling)
□ Pale urine
□ Cold Limbs

Spleen ___

□ Worry
□ Sluggish or foggy thinking
□ Poor Appetite
□ Fatigue
□ Weakness of limbs
□ Loose stools
□ Nausea
□ Full sensation in chest & belly
□ Heavy feeling in head & limbs
□ Abdominal distention after eating
□ Undigested food in stools
□ Weakness of the four limbs
□ Chilliness - cold limbs
□ Edema
□ Uterine prolapse
□ Heavy sensation in abdomen
□ Hemorrhoids
□ Varicose veins
□ Blood in stool/urine
□ Excess menstrual bleeding
□ Cold feeling in belly improved by warmth
□ No thirst
□ Thirst without desire to drink
□ Vomiting
□ Abdominal pain
□ Loose, foul-smelling stools
□ Burning sensation in anus
□ Scanty, dark-colored urine
□ Low-grade fever
□ Headache

Stomach ___

□ Abdominal discomfort
□ Mild abdominal pain
□ Lack of appetite
□ Lack of taste
□ Loose stools
□ Fatigue esp. in the morning
□ Weak limbs
□ Prefer warm drinks & foods
□ Vomiting of clear fluid
□ Lack of thirst
□ Cold limbs
□ General fatigue
□ Severe abdominal pain with vomiting
□ Feeling of fullness after eating
□ Fever or feeling warm in PM
□ Dry mouth esp. in afternoon
□ Constipation with dry stools
□ Burning sensation in stomach
□ Vomit soon after eating
□ Sour regurgitation
□ Bad breath
□ Strong thirst for cold drinks
□ Constant hunger
□ Gum swelling, pain & bleeding
□ Belching
□ Hiccough
□ Insomnia
□ Stabbing pain in epigastrium
□ Pain after eating
□ Vomiting of dark blood
□ Blood in the stools

Heart ___

□ Over excitement
□ Palpitations
□ Panic attacks
□ Dizziness
□ Pale complexion
□ Lassitude of spirit
□ Dizziness
□ Palpitation
□ Panic attacks
□ Shortness of breath
□ Spontaneous sweating
□ Oppression in chest
□ Chest pain
□ Cold extremities
□ Feelings of cold
□ Poor memory
□ Mental restlessness
□ Anxiety
□ Easily startled
□ Insomnia
□ Profuse dreaming
□ Night sweats
□ Low grade fever
□ Heat in palms, soles, and chest
□ Ulcers of mouth or tongue
□ Blood in urine

Small Intestine ___

□ Abdominal pain
□ Tongue ulcers
□ Scanty, dark, painful, or bloody urination
□ Insomnia
□ Mental restlessness
□ Throat pain
□ Thirst
□ Sudden hearing loss
□ Twisting pain in the lower abdomen that may radiate to the lower back
□ Abdominal distention
□ Pain is worse with pressure
□ Borborygmus (stomach rumbling)
□ Flatulence that relieves pain
□ Testicular pain
□ Violent abdominal pain that is worse with pressure
□ Constipation
□ Vomiting
□ Abdominal pain relieved by warmth and pressure
□ Diarrhea
□ Pale and copious urination
□ Desire for warm liquids

Liver ___

□ Anger
□ Depression
□ Anxiety
□ Frustrated
□ Poor concentration
□ Distention and pain along the sides of the abdomen
□ Frequent sighing
□ Sensation of a lump in the throat with trouble swallowing
□ Alternating Constipation and diarrhea
□ Irregular elimination
□ Scanty menstruation and/or amenorrhea
□ Hypertension
□ Numbness of the limbs
□ Muscular weakness
□ Muscle spasms
□ Muscle cramps
□ Abdominal distention
□ Acid reflux
□ Irregular menstruation
□ Painful menstruation
□ Premenstrual breast tenderness
□ PMS
□ Irregular periods
□ Dark and clotted menstrual blood
□ Fixed and stabbing abdominal pain
□ Vomiting of blood
□ Red face and eyes
□ Irritability
□ Pale, brittle nails
□ Stress
□ Pain in the scrotum/testes
□ Straining of testes or contraction of scrotum
□ Jaundice
□ Nausea and vomiting
□ Tinnitus or deafness
□ Temporal headache
□ Migraine
□ Dizziness
□ Thirst
□ Bitter taste in the mouth
□ Constipation with dry stools
□ Insomnia with dream disturbed sleep
□ Dark yellow urine
□ Blurred vision or floaters
□ Vaginal discharge and/or vaginal itching
□ Loss of appetite

Gallbladder ___

□ Difficult making a decision
□ Pain and distention along sides of abdomen
□ Nausea
□ Vomiting
□ Inability to digest fats
□ Yellow complexion
□ Bile backed up
□ Scanty, dark yellow urine
□ Fever
□ Thirst without desire to drink
□ Bitter taste
□ Dizziness
□ Blurred vision
□ Nervousness
□ Timidity
□ Propensity to being easily startled
□ Lack of courage and initiative
□ Sighing

Kidney ___

□ Fearful
□ Slow mental and physical development as a child
□ Poor skeletal development and brittle bones
□ Soreness and weakness in the lumbar area and knees
□ Premature graying and hair loss
□ Dental and teeth problems
□ Mental retardation
□ Poor memory
□ Premature aging
□ Premature senility
□ Dizziness
□ Deafness and/or tinnitus
□ Low sex drive
□ Infertility
□ Chills and aversion to cold
□ Cold limbs
□ Swollen hands and feet
□ Apathy and/or lethargy
□ Soreness and cold in the lumbar region
□ Weakness and cold of knees
□ Impotence or frigidity
□ Sterility
□ Copious clear urine
□ Frequent urination or incontinence
□ Reduced urine and edema
□ Loose teeth
□ Deafness
□ Loose stool, especially early AM
□ Asthma or shortness of breath on exertion
□ Hot palms and/or soles
□ Red cheek bones
□ Night sweats
□ Afternoon fever
□ Constipation
□ Dark urine
□ Thirst
□ Premature ejaculation
□ Nocturnal emission (especially with dreams)

Bladder ___

□ Frequent or urgent urination and pain or burning during urination
□ Difficult urination, dark yellow, or cloudy urination
□ Gravel or Stones in the urine
□ Fever
□ Thirst
□ Frequent and urgent urination, or difficult urination
□ Heavy sensation in the lower abdominal region and urethra
□ Pale cloudy urine
□ Frequent, pale, and copious Urination
□ Incontinence
□ Lower back pain

Stress

How would you rate your overall stress level:

□ **Acute** (occurs for short periods of time causing anger, irritability, anxiety, periods of depression, headache, pain, stomach upset, dizziness, heart palpitations, shortness of breath, hypertension and bowel disorders)

□ **Episodic** (will last longer than acute stress causing periods of intermitted depression, anxiety disorders, emotional distress, ceaseless worrying, and persistent physical symptoms similar to those found in acute stress. Symptoms often associated with Type A personality)

□ **Chronic** (brought on by long-term exposure to stressors that cause more serious and chronic health issues such as chronic fatigue, clinical depression, sleep disorders, high blood pressure, auto-immune disorders, etc)

□ **Mild** (Symptoms are mild and dissipate quickly. No long term effects)

Do you receive weekly counseling/psychotherapy? _____

Do you regularly do any awareness practices (meditation, yoga, tai chi, prayer, affirmations, etc.) Yes No

What are the primary causes of stress in your life? _____

Sleep

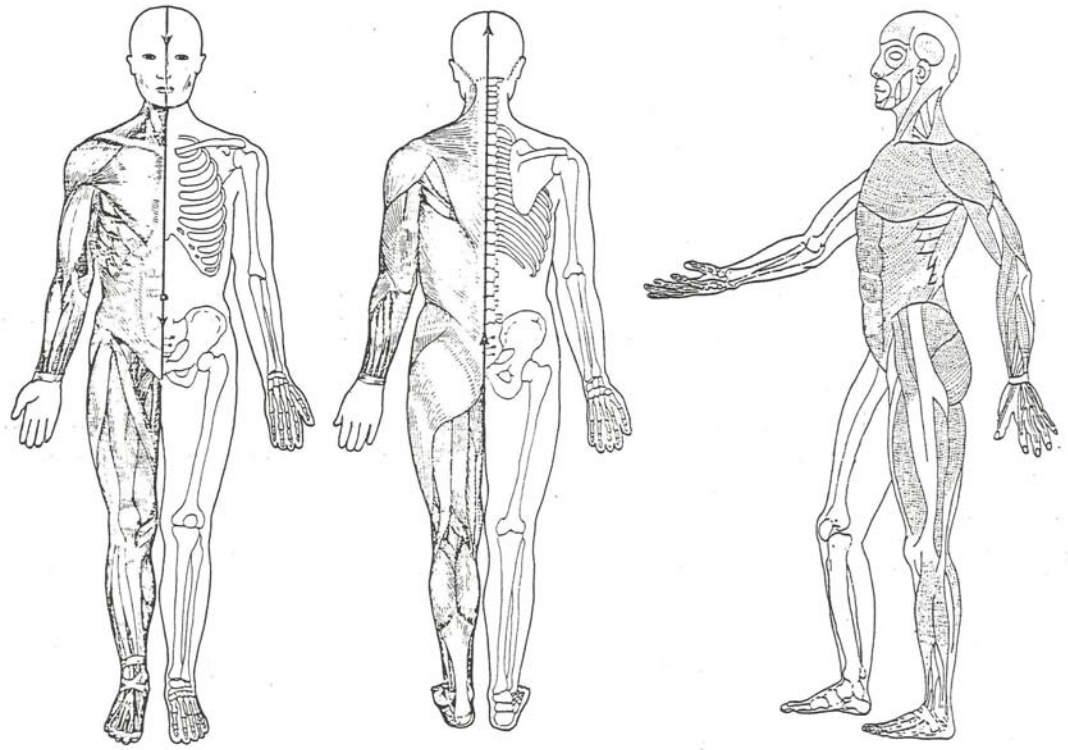
Do you sleep well? □ All the time □ Most of the time □ Some of the time □ Hardly ever

Do you fall asleep easily? Yes No
Do you feel rested when you wake? Yes No
Do you wake during the night? Yes No
Do you fall back to sleep easily? Yes No
Do you have lots of dreams? Yes No
Do you have sleep apnea? Yes No
Do you get night sweats? Yes No
Do you nap during the day? Yes No

Average hours of sleep per night: _____ Energy level (10 being best)? 1 2 3 4 5 6 7 8 9 10

Neuromuscular Pain

Please circle the areas of pain or discomfort.



Describe your pain:
□ Dull
□ Achy
□ Sharp
□ Cramping
□ Burning
□ Numbness
□ Fixed
□ Refers
□ Stiffness
□ Swelling
□ Moves around
□ Throbbing
□ Constant
□ Comes & goes
□ Worse AM
□ Worse PM
□ Worse in cold weather
□ Worse in hot weather

Does heat make it feel better? Yes No Does cold make it feel better? Yes No

Have you used any self-care techniques (cold/heat pack, self massage, biofeedback, etc.)? Yes No

Have you received any physical therapy or other types of therapy for your pain? Yes No

Please list:_____

Do you take any prescription drugs or over-the-counter drugs for your pain? Yes No

Specify: _____

Body Temperature

Check all that apply to you:
□ Feel cold often
□ Dislike the cold
□ Cold hands
□ Cold Feet
□ Feel hot often
□ Dislike the heat
□ Afternoon flushes
□ Night sweats
□ Perspire easily
□ Lack of perspiration
□ Heat in soles, hands, and chest

Physical Activity

Do you exercise? Yes No How often? _____ How long? _____

What types of exercise do you do? _____Do you like to exercise? Yes No

What kind of work do you do? _____ Hours per week: _____

How many hours spent at the computer daily? _____ Hours of TV you watch daily: _____

Check physical activities you enjoy:

□ Walking	□ Spinning	□ Hiking	□ Personal training	□ Yoga
□ Running	□ Camping	□ Team sports	□ Pilates	□ Tai chi
□ Swimming	□ Boating	□ Weight training	□ Dance	□ Qi gong
□ Cycling	□ Outdoor sports	□ Stretching	□ Zumba	□ Martial arts

Are there any reasons and/or conditions that prevent you from exercising regularly? Yes No

Specify: _____

Diet

How is your appetite? _____ How many meals per day do you eat? _____

How often do you have a bowel movement? _____

Are you thirsty? _____ How much water do you drink per day? _____

Do you prefer cold or hot beverages? _____Do you drink caffeine? _____ How many cups per day? _____

List other beverages you drink including juice, rice milk, almond milk, soy milk, tea, etc:

_____

What dairy products do you eat? _____

Are you a vegetarian or vegan? _____List sources of meat/protein: _____

What % of your diet is organic? _____ Do you have any particular cravings? _____

List any food allergies or sensitivities: _____

Do you eat regularly at fast food restaurants? _____ Times per week you eat out? _____

Do you eat a lot of processed food? _____ Do you eat late at night? _____ Do you chew your food well? ____

Do you think you get enough fresh fruits, vegetables, and whole grains daily? _____

Do you drink alcohol? _____How much? _____ Do you smoke cigarettes? _____ How much? _____

Do you take any other recreational drugs? _____

How would you describe your diet? □ Unhealthy □ Fair □ Good □ Fantastic

How would you rate your cooking skills on a scale of 1-10 (10 being best)? 1 2 3 4 5 6 7 8 9 10

Are you ready and willing to make changes in your diet if need be? _____

Men's Health

Check all that apply to you:

□ Erectile dysfunction	□ Testicular pain	□ STD	□ Infertility
□ Low libido	□ Premature ejaculation	□ Prostrate issues	□ Varicocele

Any other issues I should be aware of: _____ Please specify: _____

Women's Health

Are you currently pregnant or trying to get pregnant? _____ If pregnant, how many weeks? _____

Are your periods regular ((26-32 days)? _____ If not, describe: _____

How many days does your period last? _____

Please check any of the following that apply to you:

□ Birth control pills	□ PMS	□ Breast cancer	□ Vaginal discharge
□ Painful periods	□ Pre-menstrual spotting	□ Breast lumps	□ Yeast infections
□ Heavy flow		□ Fibroids	□ Menopause
□ Clots	□ Mid-cycle spotting	□ Migraine	□ Hot flashes
□ Anemia	□ Irritability	□ Infertility	□ Night sweats
□ Bruise easily	□ Insomnia	□ Endometriosis	□ STD
□ Scanty flow	□ Breast tenderness	□ PCOS	□ HRT

Are you currently going through fertility treatment? _____ Please describe: _____

_____

How many pregnancies have you had? _____ Any miscarriages? _____

If you are in menopause or perimenopause, are you having any issues?

_____

_____

Menstrual chart (please complete)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color of menstrual blood (normal, bright red, dark, pale, rust, brown, purple)							
Amount of flow (Heavy=H, Medium=M, Light=L)							
Clots (large, small, dark, purple, red, other)							
Cramps (Mild, Medium, Severe)							
Pain (Indicate type and location - low back, headache, right ovary, etc)							
Bloating (check if yes)							
Nausea (check if yes)							

Thank you for completing this form. All information is kept confidential.