Mary Helen Robert, LAc

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Date: ______________________

Name: ____ Date of Birth: ______________________

Address:____

Phone: ______________________________ Email: ____________________________________

Gender: ____________________ Height: ____________ Weight: ____________

Married ( ) Single ( ) Widowed ( ) Divorced ( ) Separated ( ) Other ( )

In case of an emergency please contact (include name and phone number): ______________________________

____

Occupation: ____

Who referred you to this office? ____

Have you had an acupuncture treatment before? ______________________________________

Primary reason for your visit today?____

____

Present symptoms: ____

____

Are you currently working with any other health care practitioners (please list)? ______________________

____

Other areas of pain or concern: ____

____

List ALL significant hospitalizations, surgeries, accidents, traumas (include dates): ____________________

____

____

____

Please list current medications including over the counter and prescription (attach separate sheet if necessary):

Name	Dosage/ Frequency/ Duration	For what reason are you taking this?

Supplements/vitamins/herbs currently used (attach separate sheet if necessary):

Name	Dosage/ Frequency/ Duration	For what reason are you taking this?

Level of daily stress: 1 (least) ____ 1O (most).

Have you recently had any unusually stressful experiences (i.e. divorce, death of someone close, bankruptcy, loss of job, illness, injury, etc...)? Please describe. ____________________

____

What are the main stress factors in your life? ____________________

____

What are the main ways you relax and reduce stress? ____________________

____

What types of exercise do you presently participate in (How often)? ____________________

____

How many hours per week do you work/volunteer? ____________________

Are you satisfied with your primary relationship and/or your support system? ____________________

What would you describe as the dominant emotion(s) in your life right now? ____________________

____

Please describe your health and any other additional comments: ____________________

____

____

Family History:

Relationship	Alive/Deceased (age)	Present health or cause of death
Father	________	________
Mother	________	________
Siblings (gender)	________	________
	________	________
	________	________
	________	________
	________	________
	________	________

(Check all that apply to you & indicate with a "P" those symptoms experienced in the past):

Energy level/Temperature:

_____ low energy
_____ fatigue
_____ sleepy during the day
_____ feel hot
_____ feel cold
_____ intolerance of heat/cold
_____ hot palms/feet/chest
_____ head/face feels hot
_____ cold hands
_____ cold feet

Lung/Large Intestine & Associated CM functions

_____ cough (dry/with sputum)
_____ nasal problems
_____ sinus issues/congestion
_____ catch colds easily
_____ history of bronchitis
_____ shortness of breath
_____ difficulty breathing
_____ allergies
_____ asthma
_____ fever/chills
_____ sore throat
_____ sensitive/dry skin
_____ rashes/hives/eczema
_____ sadness/grief/unresolved loss
_____ tobacco use

Spleen/Stomach & Associated CM functions

_____ less than one bowel movement per day
_____ diarrhea/loose stools
_____ constipation/dry stools
_____ undigested food in stool
_____ blood or mucus in stool
_____ nausea/vomiting
_____ indigestion/heartburn
_____ abdominal pain
_____ gas/bloating
_____ pain or discomfort after eating
_____ low or excessive appetite
_____ organ prolapse
_____ general feeling of heaviness in the body
_____ bleeding/painful/swollen gums
_____ facial swelling/pain
_____ diabetes
_____ bad breath
_____ hemorrhoids
_____ bruise easily
_____ edema
_____ crave sweets
_____ tends to overthink
_____ tends to worry

Please indicate an example of (1) your diet when you have time and energy to prepare meals and (2) a typical diet when stressed or pressed for time. Please include beverages.

(1) Breakfast	Lunch	Dinner	Snack (time of day)
(2) Breakfast	Lunch	Dinner	Snack (time of day)

How many meals do you typically eat per day? ________________ How often do you eat at restaurants? ________________

Please list any dietary restrictions: ____

How much of the following do you drink per day? Coffee (cups) ______ Teas (cups) ______ Water (oz) ______

Soft drinks (oz) ______ Wine (glass) ______ Beer (oz) ______ Liquor (oz) ______

Liver/Gallbladder & Associated CM Functions:

_____ headaches/migraines
_____ dizziness/vertigo
_____ dry/red/itchy eyes
_____ blurred vision
_____ trouble with vision
_____ high stress level
_____ easily angered
_____ bad temper
_____ irritable/frustrated
_____ feel tense
_____ difficulty making plans/decisions
_____ heat in head/face
_____ lump in throat
_____ muscle tension/cramps/spasms/tremors
_____ gall stones
_____ seizure/convulsions
_____ discomfort/tightness/tension around ribcage
_____ itching/pain in genitals
_____ alternating constipation/diarrhea

Heart/Small Intestine and Associated CM Functions:

_____ palpitations
_____ rapid/irregular heart beat
_____ pacemaker
_____ chest pain
_____ mental confusion
_____ difficulty concentrating
_____ insomnia/sleep problems
_____ light sleeper
_____ dream-disturbed sleep
_____ nightmares
_____ poor memory
_____ anxiety
_____ tongue sores
_____ cries a lot
_____ numbness/tingling at extremeties

Kidney/Bladder and Associated CM Functions:

_____ low back pain/weakness
_____ weak/sore knees
_____ cold sensation in low back
_____ cold sensation in knees
_____ joint pain
_____ wake at night to urinate
_____ kidney stones
_____ bladder/kidney infection
_____ loss of bladder control
_____ retention of urine
_____ dribbling
_____ blood in urine
_____ painful urination
_____ cloudy urine
_____ urgent urination
_____ profuse/scanty urination
_____ clear/dark urine
_____ excessive hair loss/balding
_____ frequent broken bones
_____ dental problems
_____ sexual/reproductive issues
_____ infertility
_____ adrenal exhaustion
_____ night sweats
_____ hormonal imbalances
_____ increased libido
_____ decreased libido
_____ craves salt
_____ tend to be fearful
_____ lacks willpower
_____ hearing problems
_____ ringing in ears

Other:

_____ cancer
_____ CVA (stroke)
_____ thyroid disorder
_____ heart disease
_____ hepatitis
_____ autoimmune disease
_____ COPD

For Women

Are you pregnant (if so, how many months)? ________________ Trying to become pregnant? __________ Maybe? ___________

Method of birth control? ____

Age of First Menses ______ Date of Last Menses ___________ Age of Menopause _______ Hysterectomy (Date)? ____________

Typical Length of Menses (Days You Bleed) ____

Typical Length of Cycle (From the 1st Day of One Cycle to 1st Day of the Next) _________________

Check all that apply to you (*Please indicate with a "**P**" symptoms you experienced in the past):

_____ hot flashes
_____ fibroids
_____ ovarian cysts
_____ abnormal PAP test
_____ endometriosis
_____ PID
_____ PCOS
_____ vaginal infections
_____ vaginal yeast
_____ vaginal discharge
_____ vaginal itch
_____ vaginal dryness
_____ irregular menses
_____ change in menstrual flow
_____ menstrual pain
_____ clotted blood in menses
_____ PMS
_____ water retention
_____ infertility
_____ uterine bleeding
_____ breast lumps
_____ breast discharge
_____ breast pain/tenderness

Pregnancies (please include losses/terminations):

Year	Vaginal/C Section	Sex	Complications/Other things you might want to mention

For Men

Are you currently experiencing any of the symptoms below (*Please indicate with a "**P**" symptoms you experienced in the past):

_____ prostate problems

_____ delayed stream

_____ incontinence

_____ nocturnal emissions

_____ premature ejaculation

_____ impotence

_____ testicular pain

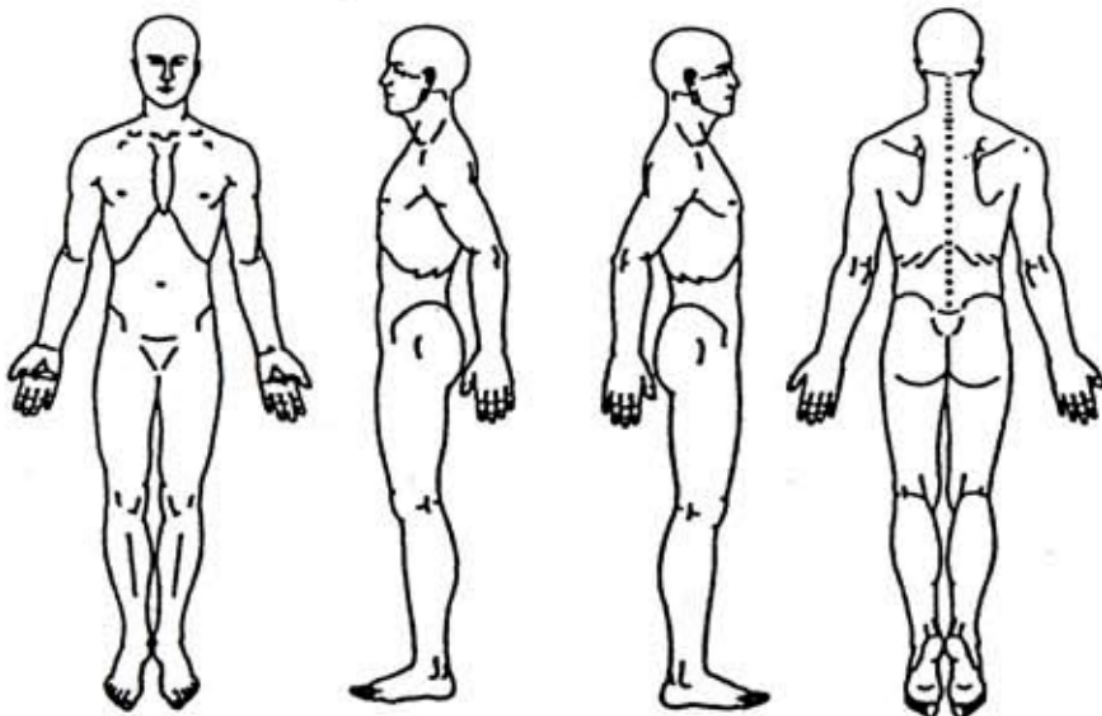
_____ groin pain

Do you have any diseases, conditions or problems not listed above (Please describe)? _______________________

____

____

Pain (Please indicate on the diagram any areas of pain or numbness)



* Our office policy requires payment on the day of your visit.
* Kindly allow 24-hour minimum notice for change or cancellation of appointment. No shows will owe for full value. We absolutely forgive emergencies.
* There will be a $30.00 fee for returned checks.

I, the undersigned, have read and understand the above policies:

Signature Date