Claudia Ward, LAc, Dipl Ac Licensed Acupuncturist Clinical Ayurvedic Specialist
Diplomate of Acupuncture Diplomate of Chinese Herbology

Medical History

NAME: ______________________________ Date:

Address ____________________________________

City/State/Zip____________________

Telephone: Home___________Cell___________ Work_____________

Email____

Birth date:___________ Age__________

Occupation______________

Referred by: ____

Main Complaints:

1.Symptom____________________________________
When did it first begin_____________________________

What makes it better? _____________________________

What makes it worse_____________________________

2. Symptom: _____________________________
When did it first begin_____________________________

What makes it better?_____________________________

What makes it worse_____________________________

3.Symptom_____________________________

When did it first begin?_____________________________

What makes it better?_____________________________

What makes it worse? _____________________________

Please check any conditions or symptoms you have or have had

Serious Illnesses/Surgeries____________________________________Other pertinent past conditions_______________________________________
Have you been under the care of a licensed Health Practitioner in the past year? ❑ Yes ❑ No
If so, for what reasons_______________________________________

List of Medications and Supplements:
Medications and pharmaceutical drugs (name and dosage)
____
____
____
____

Supplements:
____
____
____
____
____

Family History

Please check any conditions that apply to your immediate family.
❑ Cancer ❑ Diabetes ❑ Allergies ❑ Heart Disease ❑ Addictions
❑ Alcoholism ❑ High Blood Pressure ❑ Stroke ❑ Psychological Conditions

Please check if you had any of these symptoms in the last three months:

Head, Eyes, Ears, Nose, Throat

❑ Glasses ❑ Poor Vision ❑ Floaters
❑ Blurred Vision ❑ Red Eyes ❑ Night Vision Problems
❑ Glaucoma ❑ Cataracts ❑ Teeth Problems
❑ Teeth Grinding ❑ TMJ ❑ Dizziness ❑ Facial Pain
❑ Sinus Problems ❑ Recurrent Sore Throat
❑ Enlarged thyroid ❑ Swollen Glands ❑ Ringing in Ears
❑ Poor Hearing ❑ Earaches ❑ Vertigo
❑ Headaches ❑ Migraines ❑ Dizziness

Respiratory

❑ Asthma ❑ Shortness of Breath ❑ Cough ❑ Allergies ❑ Frequent Colds

Cardiovascular
❑ High Blood Pressure ❑ Chest Pain ❑ Low Blood Pressure ❑ Palpitations
❑ Swelling of hands/feet ❑ Irregular Heartbeat ❑ High Cholesterol
❑ Circulation

Gastrointestinal
❑ Abdominal/ Stomach Pain ❑ Belching ❑ Excessive Gas
❑ Burning Indigestion ❑ Vomiting ❑ Nausea
❑ Heavy after eating ❑ Sleepy (Low Energy) after Eating
❑ Bloating ❑ Constipation ❑ Food Particles in Stool
❑ Diarrhea ❑ Gallstones ❑ Candida ❑ Liver Problems

Musculoskeletal
❑ Neck/Shoulder Pain ❑ Upper Back Pain ❑ Low Back Pain
❑ Sciatica ❑ Joint Pain ❑ Fibromyalgia
❑ Arthritis ❑ Carpal Tunnel ❑ Knee Pain
❑ Tendonitis ❑ Herniated Disc ❑ Other
❑ Foot/Ankle Pain ❑ Hand/wrist Pain ❑ Knee Pain
❑ Hip Pain ❑ Limited Range of Motion

Skin and Hair
❑ Rashes ❑ Psoriasis ❑ Hair Loss
❑ Eczema ❑ Acne ❑ Fungal Infections
❑ Other

Psychological
❑ Worry ❑ Anxiety ❑ Overwhelm ❑ Insomnia
❑ Poor Memory ❑ Depression ❑ Sadness ❑ Lethargy
❑ Irritability ❑ Addictions ❑ Eating Disorders ❑Other
❑ Binge Eating

Genito- Urinary
❑ Frequent Urination ❑ Pain on Urination ❑ Unable to hold urine
❑ Decreased Libido ❑ Kidney Stones
❑ Diabetes

General Symptoms
❑ Weight Gain ❑ Weight Loss ❑ Fatigue ❑ Night Sweats ❑ Muscle Cramps ❑ Low Immune System

Gynecology
❑ Irregular Periods ❑ Painful Periods ❑ PMS ❑ Fibroids
❑ Vaginal Discharge ❑ Breast Lumps ❑ Hot Flashes
❑ Vaginal Dryness ❑ Painful Sex ❑ Low Libido
❑ Age at Menopause_____ ❑ # Pregnancies__________
❑ Date of last Period______________________________

Diet

What do you eat on a regular basis?

BREAKFAST________________________________
____

LUNCH________________________________
____

DINNER_______________________________

SNACKS________________________________

How many cups of caffeinated beverages do you drink per day?
#______types of caffeinated beverages: coffee/tea/soda

How many cups of non-caffeinated beverages do you drink?

#____types of beverage: herbal tea/water/milk/juice/other

How much water do you drink per day__________

Do you exercise regularly? ❑ Yes ❑ No
What type of exercise__________________________length of time_____________

# of glasses of alcohol per week? ____what kind? ________

Please inform us of any other problems you would like to discuss: