BAYSIDE ACUPUNCTURE
HEALTH ASSESSMENT

Name…… …… D.O.B…… ..M / F
Address…… ……..
Suburb……State……Post…… ……..
Home Phone……Mobile……
Email Address:…… ……
Emergency contact name & number…… ……..
Doctor's name & no…… Occupation…… ……..
How did you hear about us?..... ……..

What is your reason for visiting us (main complaint)?.....
……
……
……
Current symptom details (onset, severity, location);……
…… ……..
What has been your treatment to date?..... ……

Please list any current medical conditions;…… ……
…… ……..
Please list any medications you are taking; ……
Please list your past medical conditions;……
…… ……..
Have you ever had any surgery's (trauma's?..... ……
…… ……

Are you pregnant? Yes No Possibly

Recreational Activities…… ……..
Lifestyle Alcohol ? Yes / No Qty…….. Daily /weekly……Smoking ? Yes / No Qty…… ……..

Dietary Considerations please circle: Vegetarian Vegan Allergies Gluten Intolerant Dairy Intolerant
Breakfast:……
Lunch:……
Dinner:……
Snacks:……
Vitamins / Supplements…… ……

I hereby declare that all information given is accurate to my knowledge and I give consent to be treated with acupuncture and herbal medicine for my conditions. NAME…… DATE……..

Please circle the most appropriate answer

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GENERAL VITALITY

Are you often tired ? **Yes No Sometimes**
Your general energy levels (1-10) 1 being the lowest……..
Is your energy low in the - Morning / afternoon / evening
Do you experience feelings of heaviness **Yes No Sometimes**
Do you have frequent colds / flu / infections **Yes No Sometimes**
Do you experience shortness of breath
with mild activity **Yes No Sometimes**
Do you have a good libido **Yes No Sometimes**
Do you experience dizziness **Yes No Sometimes**
Do you experience chest palpitations **Yes No Sometimes**

PAIN

Do you experience any unexplained pain **Yes No Sometimes**
Is your pain Sharp / Stabbing / Moving / Fixed / Dull
Is it worse in humid / wet / hot / cold / windy weather
Is your pain relieved by rest / heat / massage / movement
Do you experience headaches regularly **Yes No Sometimes**
Location of headache / front / sides / back / top / behind eyes
Do you have any lumps or swellings
associated with pain or discomfort **Yes No Sometimes**
Have you recently suffered
trauma / haemorrhage **Yes No Sometimes**

DIGESTIVE

Do you have a good appetite **Yes No Sometimes**
Are you most hungry in the morning / lunch / evening / allways
Do you suffer from abdominal /pain/bloating **Yes No Sometimes**
Is it better / worse after eating **Yes No Sometimes**
Are you often / rarely thirsty **Yes No Sometimes**
Do you experience any of the following
*Nausea **Yes No Sometimes**
*Vomiting **Yes No Sometimes**
*Sour regurgitation **Yes No Sometimes**
*Heart burn / Reflux **Yes No Sometimes**
*Bleeding gums / Mouth ulcers **Yes No Sometimes**
*Hiccups / Belching **Yes No Sometimes**
*Bitter / sweet / dry / poor taste in mouth **Yes No Sometimes**

STOOLS

How often do you defecate daily (average)……..

URINATION

Do you experience any of the follo owing ?
*Difficult urination **Yes No Sometimes**
*Burning urination **Yes No Sometimes**
*Scanty urination **Yes No Sometimes**
*Blood in the urine **Yes No Sometimes**
*Excesive daytime urin **Yes No Sometimes**
*Excesive nighttime urination **Yes No**
*Dribbling urination **Yes No**
*Incontinence **Yes No Sometimes**

SLEEP

Average hours of sleep per night …….
Do you have trouble getting
to sleep **Yes No Sometimes**
Do you wake up freque **Yes No Sometimes**
during the night
Do dreams disturb **Yes No Sometimes**
your sleep
Do you sweat or feel **Yes No Sometimes**
hot at night
Do you feel well rested **Yes No Sometimes**
when you wake

MENTAL / EMOTIONAL

Do you often feel
*Anxious **Yes No Sometimes**
*Agitated **Yes No Sometimes**
*Nervous **Yes No Sometimes**
*Angry / Frustrated **Yes No Sometimes**
*Depressed **Yes No Sometimes**
*Confused **Yes No Sometimes**
*Irritable **Yes No Sometimes**
*Restless day / night **Yes No Sometimes**
*Disorientated **Yes No Sometimes**
*Forgetfull **Yes No Sometimes**
*Worried / obsessive **Yes No Sometimes**
*Moody **Yes No Sometimes**
*Fearfull / Frightened **Yes No Sometimes**

HOT / COLD

Do you sweat

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Do you suffer from constipation **Yes No Sometimes**
Do you suffer from diarrhoea / Loose stools **Yes No Sometimes**
Do you experience flatulence **Yes No Sometimes**
Do you experience alternating
constipation and diarrhoea **Yes No Sometimes**
Do your stools
*Contain undigested food **Yes No Sometimes**
*Contain a strong odour **Yes No Sometimes**
*Contain any blood **Yes No Sometimes**
Do you experience any
itching / burning sensation of anus **Yes No Sometimes**
Is the shape of your stools
*Consistant **Yes No Sometimes**
*Pepple like **Yes No Sometimes**
*Thin **Yes No Sometimes**
*Small and bitty **Yes No Sometimes**
*Constantly changing **Yes No Sometimes**

GENERAL

Do you get a sore back and knees **Yes No Sometimes**
Do you get a tight neck and shoulders **Yes No Sometimes**
Do you bruise easily **Yes No Sometimes**
Do you suffer from muscle weakness **Yes No Sometimes**
Do you get muscle cramps / spasms **Yes No Sometimes**
Do you get tinnitis / or hearing problems **Yes No Sometimes**
Do you suffer from weak bones / teeth **Yes No Sometimes**
Do you suffer from odema / swelling of the
Face / Arms / Torso / Legs / Ankles / Body **Yes No Sometimes**
Do you suffer from Impotence /
Premature ejactulation / noctural emisions **Yes No Sometimes**
Do you suffer from prolapes of the
Stomach / Uterus / Anus / Vagina **Yes No Sometimes**
Do you experience tightness / pain
in the sides or ribs **Yes No Sometimes**
Do you experience dermatitis / eczema /
psoriasis or other skin conditions **Yes No Sometimes**

spontaneouesly **Yes No Sometimes**
Is the sweating worse in the
Morning / Afternoon / E **Yes No Sometimes**
Do you dislike heat **Yes No Sometimes**
Do you dislike cold **Yes No Sometimes**
Do you get cold
hands and feet **Yes No Sometimes**
Do you have trouble
staying warm **Yes No Sometimes**
Do you get hot
hands and feet **Yes No Sometimes**
Do you get dry
Hair / Skin / Eyes **Yes No Sometimes**
Do you get brittle
nails **Yes No Sometimes**

WOMEN

Do you have a regular
cycle **Yes No Sometimes**
How many days is your
cycle……
Is the flow Bright red / Dark / Heavy
Light / Irregular / Scanty / Contains Clots
Do you experience **Yes No Sometimes**
*Painfull periods **Yes No Sometimes**
*Breast distention **Yes No Sometimes**
*Breast pain **Yes No Sometimes**
*Mood swings **Yes No Sometimes**
*Abdominal Pain **Yes No Sometimes**
*Headaches **Yes No Sometimes**
*Sweet cravings **Yes No Sometimes**
Do you experience
vaginal discharge **Yes No Sometimes**
Obstetric history:
How many times have
you been pregnant…….
How many children do you have…….