



Patient Name: \_\_\_\_\_

**Urination and Reproductive:**

(Circle all that apply):

Frequent Urination      Dark Urine      Painful Urination      Urinary Incontinence      Frequent UTIs  
Low Libido      Sexually Transmitted Infection      Kidney/Urinary Stones  
Other Kidney/ Bladder Disorder (please specify): \_\_\_\_\_

*Men Only*

Erectile Dysfunction      Prostate Disease/ Enlarged Prostate

*Women Only*

Age of first menses: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_  
Days between Periods: \_\_\_\_\_ Length of menstruation: \_\_\_\_\_  
Age of menopause: \_\_\_\_\_  
# of pregnancies: \_\_\_\_\_ # of live births: \_\_\_\_\_ # of miscarriages/ abortions: \_\_\_\_\_  
Do you practice birth control? \_\_\_\_\_ If so, what kind: \_\_\_\_\_  
Is it possible that you are pregnant? \_\_\_\_\_  
Do you plan to become pregnant in the next three months? \_\_\_\_\_

*Circle all that apply:*

Endometriosis      Hysterectomy      Recurrent Yeast Infections  
Vaginal Discharge      Breast Lumps      Polycystic Ovarian Disease  
Painful Menstruation      Heavy Menstruation      Light Menstruation  
PMS      Difficult Pregnancy/Childbirth      Problems Breastfeeding

**Head/Ear/Nose/Throat**

(Circle all that apply):

Recurrent Headache      Blurry Vision      Floaters in Eyes      Other Eye Problem  
Ringing in Ear      Hearing Loss      Ear Infections      Other Ear Problem  
Sinus Problem      Allergies      Dry Throat      Recurrent Sore Throat  
Other Throat Problem      Jaw Tightness/ TMJ      Grinding Teeth      Face Pain

**Lung and Heart**

(Circle all that apply):

Heart Disease      High Cholesterol      High Blood Pressure      Low Blood Pressure  
Stroke      Pacemaker      Heart Palpitations      Rapid Heart Beat  
Chest Pain      Chest Tightness      Anemia      Hemophilia  
Other Bleeding Disorder      Blood-Thinning Medications  
Persistent Cough      Asthma / Bronchitis/ Tuberculosis      Other Lung Disorder

Are you currently a smoker? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_

**Skin and Musculo-skeletal**

(Circle all that apply):

Arthritis      Tendonitis      Herniated Discs  
Eczema      Psoriasis      Dry skin      Infectious Skin Disease  
Bruise Easily      Flush Easily      Hot Flashes      Night Sweats  
Sweating Easily      Excessive Sweating      Chilled Easily      Cold Hands and Feet

Where do you feel pain? \_\_\_\_\_

Is the pain:      Dull      Aching      Stabbing      Throbbing

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**Sleep**

(Circle all that apply):

Trouble Falling Asleep      Waking During Night      Light Sleep      Restless Sleep  
Snoring      Sleep Apnea      Groggy in Morning  
Number of hours sleep/night: \_\_\_\_\_

**Mental and Emotional**

(Circle all that apply):

Epilepsy/ Seizures      Dizziness/ Fainting      Poor Memory  
Alcohol Abuse      Drug Abuse      Suicide Attempts  
Anxiety      Panic Attacks      Easily Worried  
Depression/ Easily Sad      Withdrawn/ Unmotivated      High Stress  
Irritability      Short Temper      Manic Episodes  
Other Emotional/ Psychological Disorder (please specify): \_\_\_\_\_

**Other Conditions**

(Circle all that apply):

Multiple Sclerosis      Autoimmune Disorder      Hepatitis/Liver Disorder      Enlarged Organ  
Cancer      Metal Plate      Implanted Device  
Other, Please Specify \_\_\_\_\_

**Medications** (please list any *prescribed or over-the-counter medications or supplements* that you are currently taking or have taken in the past three months):

Name of Medication	Date Began Taking	Dose and Frequency (e.g. 200 mg, 2x day)	Reason for Taking	Side Effects (if any)

Have you ever experienced an adverse side effect from herbal medicine or supplements? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

**Allergies** (please circle all that apply):

Animal products/ gelatin      Citrus      Fermented products  
Honey      Pollen      Shellfish  
Soy      Talc      Wheat

Other (please specify): \_\_\_\_\_  
If no known allergies, please check here: \_\_\_\_\_

*Please note: It is your responsibility to inform River Valley Acupuncture if any of the above information changes, or if there are any changes to your health that may impact your treatment.*