

SISTERS ACUPUNCTURE CENTER

Name	Home Phone	Work Phone	
Address	City	State	Zip
Today's Date	Birth Date	Height	Weight

Indicate with **one** check any condition that you sometimes experience, use **two** checks for those that occur often, and **three** checks for symptoms that are a major concern.

WATER ELEMENT:

1	2	3	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower back ache / neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Edema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Darkness under eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional instability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aversion to cold
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair thinning or loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pre-mature aging
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Perspire very easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness of legs / knees
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthmatic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight change
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reduced sexual energy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes

WOOD ELEMENT:

1	2	3	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor eyesight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes simples
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Warts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion, spasms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indecisive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fullness below ribs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder / neck tension
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia 11 PM - 3 AM

FIRE ELEMENT:

1	2	3	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Scalp
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes, skin eruptions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cysts, tumors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat / tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic swelling
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot palms & soles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aversion to heat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bitter taste in mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facial redness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching / burning skin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thirst
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vivid dreaming
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dark urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats

METAL ELEMENT:

1	2	3	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shallow breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal infection

OTHER:

1	2	3	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica / nerve pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis

EARTH ELEMENT:

1	2	3	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomachache / ulcer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Halitosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores in mouth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strong appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weak appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low body weight

(To be filled in by practitioner)

Right Pulse
Left Pulse
Tongue
Tongue fur

SISTERS ACUPUNCTURE CENTER

Indicate with **one** check any condition that you sometimes experience, use **two** checks for those that occur often, and **three** checks for symptoms that are a major concern.

FEMALE CLIENTS ONLY:

1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Vaginal infection
 Yeast infection
 Urinary tract infection
 Ovarian cyst
 Pelvic inflammatory disease

1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Breast lumps
 Irregular periods
 Menstrual cramping
 Pre-menstrual syndrome
 Infertility
 Excessive Bleeding

1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Genital burning
 Positive PAP
 Hemorrhoids
 Anal fissure
 Indicate number of children you've had

MALE CLIENTS ONLY:

1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Prostatitis
 Nocturnal emission

1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Burning urination
 Pre-mature ejaculation

1	2	3
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Urinary incontinence
 Impotence

SISTERS ACUPUNCTURE CENTER

Indicate all surgeries you have had and give approximate dates:

List any pharmaceuticals you are now taking:

Choose one or two EMOTIONS that seem predominant in your life:
(frequently experienced, difficult to express, or in some way influential)

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had: (e.g. divorce, change of residence, injury, death in family, bankruptcy, etc.)

Date: Event:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Do you now undertake or have you undertaken a restricted diet? Please describe and indicate when

Describe your current program of physical fitness:

What types of acute illness do you get, and roughly how often have you experienced them during the last five years?

Please provide any additional information about yourself or your condition that might not have been covered by the above questions:
