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FORSBERG ACUPUNCTURE

PATIENT HEALTH SHEET

PLEASE PRINT

Date: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ (MONTH) | _____ (DAY) | _____ (YEAR) Height: _____ Weight: _____

Occupation: _____ Referred By: _____

Ever treated with acupuncture before? NO ☐ YES ☐

CURRENT HEALTH CARE

Are you currently on any medication? NO ☐ YES ☐ If YES, please list:

Are you currently under the care of any other health care providers? NO ☐ YES ☐ If YES, please list:

Why are you here for treatment? What is your **chief complaint**?

List any **chronic or serious illness**:

CLIENT PROFILE

Indicate with **1** check (√) any condition that you sometimes experience. Use **2** checks (√ √) for conditions occurring more often; use **3** checks (√ √ √) for symptoms that are of major importance.

WATER ELEMENT ~ KIDNEY

____ Hearing loss
____ Dizziness
____ Low backache/neck pain
____ Sinus congestion
____ Edema
____ Darkness under eyes
____ Emotional instability
____ Aversion to cold
____ Hair thinning/loss
____ Premature aging
____ Frequent urination
____ Kidney stones
____ Perspire very easily
____ Weakness of legs/knees
____ Asthmatic cough
____ Rapid weight gain
____ Loose teeth
____ Reduced sexual energy
____ Thyroid problems
____ Diabetes

WOOD ELEMENT ~ LIVER

____ Headaches
____ Migraines
____ Ringing in the ears
____ Poor eyesight
____ Eye infections
____ Dry eyes
____ Eczema
____ Shingles
____ Herpes simplex
____ Warts

(Continued on back)

____ Nervousness
____ Convulsions, spasms
____ Irritability
____ Constipation
____ Hemorrhoids
____ Hepatitis
____ Ulcer
____ Vomiting
____ Gallstones
____ Indecisiveness
____ Fullness below the ribs
____ Shoulder/neck tension
____ Insomnia 11pm – 3am

FIRE ELEMENT ~ HEART
____ Dry scalp
____ Skin eruptions, rashes
____ Cysts, tumors
____ Ear infections
____ Sore throat/tonsillitis
____ Lymphatic swelling
____ Hot palms/soles
____ Heart palpitations
____ Aversion to heat
____ Bitter taste in mouth
____ Gum problems
____ Nose bleeds
____ Itching/burning skin
____ Hot hands/feet
____ Thirst
____ Vivid dreaming
____ Dark urine
____ Night sweats

EARTH ELEMENT ~ SPLEEN
____ Flatulence
____ Food allergy
____ Stomachache/ulcer
____ Diarrhea
____ Anemia
____ Halitosis
____ Mouth sores
____ Heartburn
____ Strong appetite
____ Weak appetite
____ Nausea/vomiting
____ Abdominal bloating
____ Low body weight

METAL ELEMENT ~ LUNG
____ Bronchitis
____ Asthma
____ Shallow breathing
____ Short of breath
____ Cough
____ Sinus congestion
____ Nasal infections

OTHER
____ Fatigue
____ Arthralgia
____ Sciatica/nerve pain
____ Cold hands/feet
____ Bursitis

MALE PATIENTS
____ Prostatitis
____ Urinary incontinence
____ Impotence
____ Burning urination

FEMALE PATIENTS
____ Yeast or vaginal infections
____ Urinary tract infections
____ Ovarian cysts
____ Genital herpes
____ Pelvic inflammatory disease
____ Breast lumps
____ Irregular periods
____ Menstrual cramping
____ Premenstrual syndrome
____ Infertility
____ Excessive bleeding
____ Genital burning
____ Positive PAP
____ Anal fissure

Number of children: _____

Cycle lengh: _____

Days of bleeding: _____

Clots: YES ☐ NO ☐

Indicate any/all **surgeries** you have had, listing approximate dates:

1.

2.

3.

Chose one or two **emotions** that seem to predominate in your life (i.e. frequently experienced, difficult to express or in some ways are influential). For example: grief, joy, anger, fear, melancholy or other.

1.

2.

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

DATE EVENT

1.

2.

3.

4.

Are you on a **restricted diet?** Please describe:

Describe your current program of **physical fitness**: