# DAY ONE

# HEALTH HISTORY QUESTIONNAIRE

**PATIENT'S NAME:** _____ **AGE:** _____ **DATE:** _____

(Physical Exam) BP: (L or R Arm) _____ SYS _____ DIA _____Pulse (before treatment) Weight: _____

BP: (L or R Arm) _____ SYS _____ DIA _____Pulse (after treatment) Temp: _____ (F)

## MAJOR COMPLAINT(S):

| 1. COMPLAINT | | 2. COMPLAINT | | 3. ANY OTHER COMPLAINT(S) |
|---|---|---|---|---|
| | | | | e.g., sinuses, asthma, hormone issues, diabetes, digestive troubles, fatigue, sleep problems, etc. |
| Onset: | How long? | Onset: | How long? | A |
| Previous Hx: | How happen? | Previous Hx: | How happen? | |
| S/SX: | | S/SX: | | B |
| Pain 1-10; 10 = worst: | | Pain 1-10; 10 = worst: | | |
| Type of pain: | | Type of pain: | | C |
| Constant/Intermittent: | | Constant/Intermittent: | | |
| Duration? daily, weekly...) | | Duration? daily, weekly...) | | D |
| Aggravates? | | Aggravates? | | |
| Makes better? | | Makes better? | | E |
| Does NOT work? | | Does NOT work? | | |
| Wes. Med DX? | | Wes. Med DX? | | Misc. Notes: |
| Misc. Notes: | | Misc. Notes: | | |

## REVIEW OF SYSTEMS

| PE | WNL | AB-NML | REASON |
|---|---|---|---|
| Constitution | | | |
| Head / Mental | | | |
| HA's | | | |
| Eyes | | | |
| Ears | | | |
| Nose | | | |
| Throat | | | |
| Chest | | | |
| Heart | | | |
| Respiratory | | | |
| Stomach | | | |
| Abdomen | | | |
| Skin | | | |

## FAMILY HISTORY

| Who | What Problems? | Are they receiving care? Yes | No |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
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| | | | |
| | | | |

**L.Ac's Signature:** _____ **TX:**_____(_____**of**_____) **or TX/HC:** (_____**of**_____)

**DAY ONE**

# HEALTH HISTORY QUESTIONNAIRE

## SLEEP PATTERNS:

Has your sleep been disrupted in any of the following ways?

1. Do you have trouble falling asleep? yes _____ no _____
2. Is your sleep restful (do you wake refreshed)? yes _____ no _____
3. Do you awaken in the middle of the night as a result of your problem(s)? yes _____ no _____
4. Do you wake earlier than you normally would? yes _____ no _____

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1. Are you discouraged with your current health status? yes _____ no _____
2. If you are NOT discouraged, what adjective best describes how you view your health? _____
3. How do your health problem(s) affect your relationship(s)? _____
   Work? _____
   Family/Friends? _____
4. What hobbies or activities would you resume if it weren't for your health issues? _____
   _____
5. Would you agree that your health seems to be having a negative affect on your life? yes _____ no _____
6. How much younger would you feel if your health concerns could be erased away? _____
7. If your health problems aren't resolved, and they have been going on for ___ months/years, what will be the result if they continue on for another ___ months/years? _____
8. On a scale of 1 -10, with ten being the highest, how committed are you of wanting to rid yourself of these problems and feeling great? _____
9. Assuming that we could help you with your condition, is there anything that would prevent you from following through with the treatment plan? yes _____ no _____
10. Are there any other barriers to your commitment, e.g., time, transportation, other?
    Please specify: _____

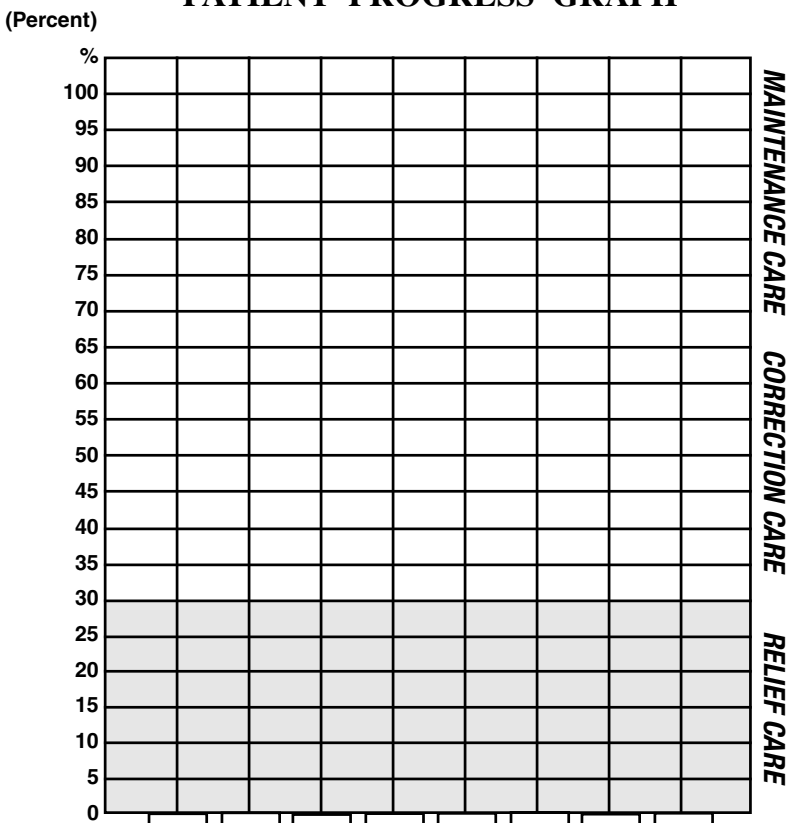
**TX:____(____of____)**

**L.Ac's Signature:** _____ **TX/HC: (____of____)**

**PATIENT NAME:** _____

**Total # of Health Boxes:** _____
**Total # of Tongue Tests:** _____
**Total # of Pulse Tests:** _____
**Total # of Chief Complaints:** _____
**Grand Total:** _____ **(100%)**
**Point Value of each:** _____

## PATIENT PROGRESS GRAPH




| R-Exam # | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Date: 20 | | | | | | | | |
| Boxes Improved | | | | | | | | |
| #CC's improved | | | | | | | | |
| # Tongues imprv'd | | | | | | | | |
| # Pulses imprv'd | | | | | | | | |
| Total Improved | | | | | | | | |
| %Improved | | | | | | | | |

**Major Complaint(s):**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

**Tongue Qualities:**

| | |
|---|---|
| Color | |
| Shape | |
| Size | |
| Coat | |

**Positive Pulse Tests:**

| R-Exam # | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Ht | | | | | | | | |
| SI | | | | | | | | |
| Liv | | | | | | | | |
| GB | | | | | | | | |
| Kid | | | | | | | | |
| UB | | | | | | | | |

| R-Exam # | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Lu | | | | | | | | |
| LI | | | | | | | | |
| Sp | | | | | | | | |
| St | | | | | | | | |
| Kid | | | | | | | | |
| UB | | | | | | | | |

**Baseline Pulse:**

| | | *Cun* | *Guan* | *Chi* |
|---|---|---|---|---|
| L | S | | | |
| | M | | | |
| | D | | | |
| R | S | | | |
| | M | | | |
| | D | | | |

**L.Ac's Signature:** _____

# ACUPUNCTURE TREATMENT PLAN

**PATIENT'S NAME:** _____ **DATE:** _____

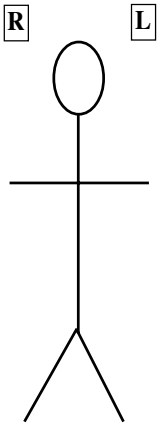
**EXISTING CONDITION(s) for which the Patient is currently being treated:**

| S COMPLAINT | STATUS %Better/Worse | PAIN 1-10; 10=worst |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| O | | |
| A | | |

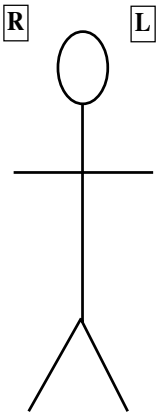
**VESSELS** (involved)

_____
_____
_____
_____
_____

**ACUPOINTS**




**RE-INSERT** (acupoints)




P

Circle which: Herbs Acup. Acup/Stim. TDP

TX PLAN: _____1x/week; _____2x/week; _____3x/week; _____other

**L.Ac's Signature:** _____ **TX TIME TOTAL:** _____ **(minutes)**

## HERBAL CONSULTATION

BP (L or R arm): _____ SYS; _____ DIA; _____ Pulse (before TX)
BP (L or R arm): _____ SYS; _____ DIA; _____ Pulse (before TX)

CHIEF COMPLAINT(s) _____

_____

_____

TCM DX: _____

Temp./Palpation DX: _____ Ear DX: _____

| | R PULSE | | | L PULSE | | |
|---|---|---|---|---|---|---|
| | Cun | Guan | Chi | Cun | Guan | Chi |
| S: | | | | | | |
| M: | | | | | | |
| D: | | | | | | |

**PULSE DX:**

_____
_____
_____
_____

**HERBAL FORMULA**

Instructions: _____ spoons; _____ x's/day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____ Total Grams: _____

**Green**

**Yellow**

**Red**

**Blue**

TX: _____ (_____of_____)

(or) TX/HC: (_____of_____)

L.Ac's Signature: _____