Ocean Integrated Wellness Center

Toms River NJ 08755
732-503-4079

Today's Date: _____/_____/_____

Name: _____ Birth Date: _____

Address: _____

Phone Number: Home Work Cell

_____

E-Mail: _____ Occupation: _____

Marital Status: _____ Education:

_____

Have you received acupuncture before? ☐ Yes ☐ No

If so, for what condition? _____ Was it helpful?

_____

MAIN COMPLAINT AND PRESENT

1. Main problem you would like us to help you with:

_____

2. How long ago did this problem begin? ☐ Sudden or ☐ Chronic

_____ Years _____ Months _____ Weeks

3. Have you been given a diagnosis for this problem? If so, what?

_____

4. What kinds of treatment have you tried?

_____

5. Are you currently receiving treatment for your problem?

_____

6. Does anything improve your problem?

_____

* Symptoms are worse with: _____

* Symptoms are better with: _____

MEDICAL HISTORY

Please list all the Medical conditions you have had

_____

_____

_____

Are you taking any medications? (Please list)

_____

_____

_____

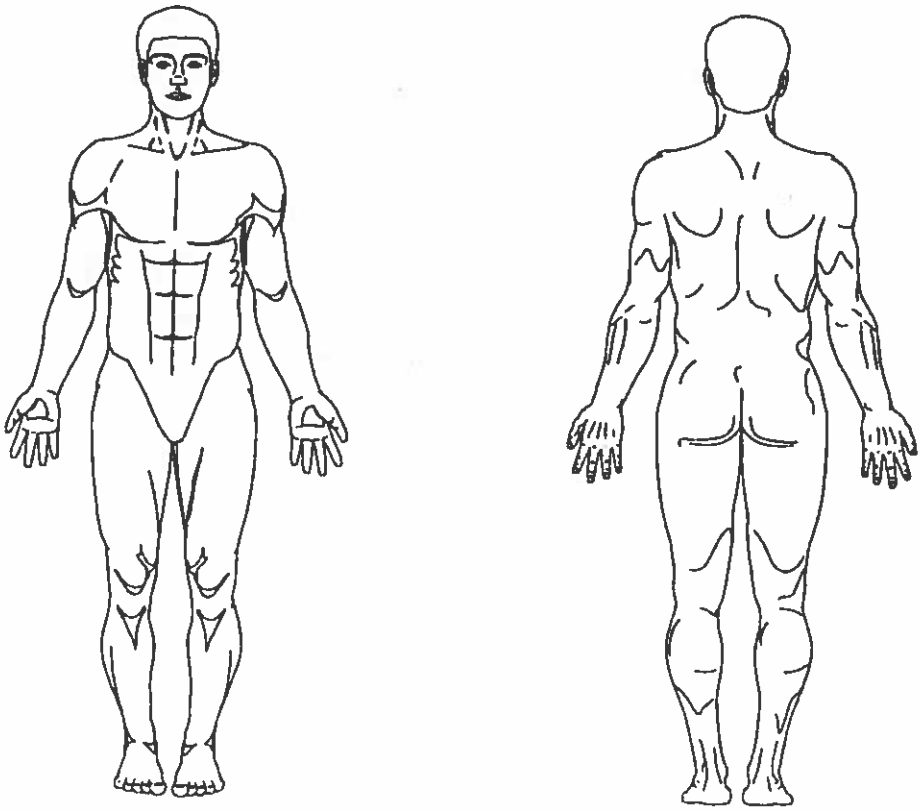
Do you have any allergies? (Please list)

_____

If female, are you currently pregnant? ☐ Yes ☐ No

If female, are you currently *trying* to get pregnant? ☐ Yes ☐ No

On the diagram, please shade in the areas associated with the symptoms of your complaint(s):



Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:

←----------→

0 1 2 3 4 5 6 7 8 9 10

No pain Severe pain

Family History: Please note all major illness in your close family, i.e. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, cancer, high cholesterol, etc.

_____

_____

_____

Please check if you have had any (in the **last 3 months**)

GENERAL

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Changes in appetite
- ❑ Weight loss/gain
- ❑ Cravings
- ❑ Peculiar tastes
- ❑ Strong thirst
- ❑ Fevers/Chills
- ❑ Sweat easily
- ❑ Localized weakness
- ❑ Bleed / bruise easily
- ❑ Sudden energy drop (time?)
- ❑ Fatigue
- ❑ Tremors
- ❑ Poor sleeping
- ❑ Heavy sleeping
- ❑ Dream disturbed sleep
- ❑ Night sweats
- ❑ Dizziness

SKIN AND HAIR

- ❑ Rashes/Hives
- ❑ Itching
- ❑ Dry skin
- ❑ Dandruff
- ❑ Ulcerations
- ❑ Eczema/Psoriasis
- ❑ Loss of hair
- ❑ Pimples/Acne
- ❑ Fungal infections
- ❑ Recent moles
- ❑ Change in hair or skin texture

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Concussions
- ❑ Glasses/Contacts
- ❑ Eye strain/pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Dry eyes
- ❑ Excessive tearing
- ❑ Poor/blurry vision
- ❑ Night blindness
- ❑ Cataracts/Glaucoma
- ❑ Spots in front of eyes
- ❑ Earaches/Infections
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Sinus problems
- ❑ Post nasal drip
- ❑ Excessive phlegm – color_____
- ❑ Nose bleeds
- ❑ Recurrent sore throats
- ❑ Swollen glands
- ❑ Sores on lips/tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Teeth problems
- ❑ Gum problems
- ❑ TMJ disorder
- ❑ Grinding teeth

❑ **Headaches** (Frontal/ Temporal/ Occipital, migraine, triggers, Frequency)?

_____

_____

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Fainting
- ❑ Cold hands/feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Phlebitis

RESPIRATORY

- ❑ Cough
- ❑ Coughing blood
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Pain with deep breath
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Production of phlegm - color?_____
  Is it ☐ thick or ☐ thin

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Hiccups
- ❑ Belching
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Mucus in stools
- ❑ Acid Regurgitation
- ❑ Abdominal pain
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Hemorrhoids/fissures

GENTIO-URINARY

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Bedwetting
- ❑ Kidney stones
- ❑ Impotency
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Premature ejaculation
- ❑ Nocturnal emissions
- ❑ Sores on genitals
- ❑ Frequent urinary tract infections
- ❑ Chronic yeast infection

MUSCULOSKELETAL

- ❑ Neck pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Hand/wrist pains
- ❑ Muscle pains
- ❑ Muscle weakness
- ❑ Cramps/spasms
- ❑ General joint pain/stiffness
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Joint with limited range of motion_____

NEUROPSYCHOLOGICAL

- ❑ Seizures
- ❑ Loss of balance
- ❑ Areas of numbness
- ❑ Tics
- ❑ Lack of coordination
- ❑ Memory loss
- ❑ Concussion
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily susceptible to stress
- ❑ History of emotional/physical abuse
- ❑ Insomnia/sleep disturbance
- ❑ Dreams a lot

GYNECOLOGY (Female Only)

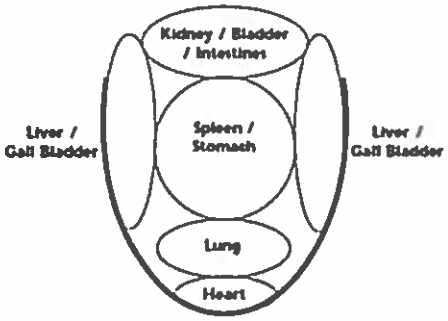
Age of first menses_____ If no longer menstruating, approximate date ceased_____

Date of last Period_____ Period cycle :_____days Duration of period:_____days

- ❑ Unusual flow (☐heavy or ☐light)
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Clots in flow
- ❑ Vaginal discharge – color_____
- ❑ Vaginal odor
- ❑ Vaginal dryness
- ❑ Vaginal sores
- ❑ Hot flashes
- ❑ Breast lumps/soreness

DIAGNOSIS FOR PRACTITIONER

♦ Objective /Physical Examination:



Tongue :

Pulse _____ b/min **Quality:** Left

Right

♦ **Eight Principle:** INTERNAL/EXTERNAL DEFICIENT/EXCESS COLD/HOT YIN/YANG

♦ **TCM Diagnosis:** _____

Chief Complaints

_____

_____

_____

_____

Clinical Diagnosis: Based upon the subjective complaints of the patient and objective examination findings, the patient appears to present the following clinical picture.

54.2 Neck Pain	M25.511 Right Shoulder Pain	M25.571 Right Ankle and Joint
54.5 Lower Back Pain	M25.512 Left Shoulder Pain	M25.572 Left Ankle and Joint
54.6 Thoracic sprain/strain	M25.551 Right Hip Pain	R51 Headache
54.12 Neck Radiculopathy	M25.552 Left Hip Pain	G43.009 Migraine w/o aura
54.17 LB Radiculopathy	M25.521 Right Elbow Pain	F41.1 General Anxiety Disorder
M25.561 Right Knee Pain	M25.522 Left Elbow Pain	R53.82 Chronic Fatigue
M25.562 Left Knee Pain	M26.60 TMJ	F51.01 Primary Insomnia

Other:

_____

_____

_____

_____

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