



PATIENT INFORMATION

THANK YOU FOR CHOOSING BEAUTIFUL AMA!

WE ARE EXCITED TO WORK WITH YOU TO BALANCE YOUR BODY AND EMOTIONS NATURALLY.

The answers you will provide on these forms, along with the discussions you will share with your practitioner all provide an overall picture of your health. This holistic view allows your concerns to be addressed from both a specific *branch* level and also a deeper *root* level.

Please take time to thoughtfully and honestly answer these questions so that the picture of your health is revealed as clearly as possible.

Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Primary Phone # (h, w, c) _____ Secondary Phone # (h, w, c) _____

E-mail Address _____

Would you like to join Beautiful Ama's email list and be the first to know about exclusive specials?

Yes No I'm already on it!

Date of Birth _____ Age _____ Weight _____ Height _____ Sex M / F

Marital Status:

Single Separated Widowed
 Married or living with significant other Divorced

Employer _____ Occupation _____

Emergency Contact Name _____ Phone (h, w, c) _____

Have you ever received acupuncture before? Yes / No Itex member? Yes / No

How did you hear about us? _____



MEDICAL HISTORY

What health concerns bring you in today?

How do these affect your daily life?

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was the diagnosis? _____

Other practitioners you are seeing:

Chiropractor

Dietitian / Nutritionist

Cranio-Sacral Therapist

Massage Therapist

Psychotherapist

Other: _____

Physical Therapist

Psychiatrist

Other: _____

Are you interested in getting more information on vitamins and supplements? Yes / No

Do you have other health concerns you wish we could help?

Major surgeries you've had and the year they occurred

Significant trauma (accidents, falls)

Have you ever been diagnosed with any of the following:

Diabetes

Low blood pressure

Anxiety

Seizures

High cholesterol

Tuberculosis

Blood clots

Anemia

Asthma

Stroke

Arthritis

IBS

Heart Attack

Fibromyalgia

Hepatitis

High blood pressure

Depression

Substance addiction

Family medical history (parents, siblings, grandparents)



PATIENT RISK ASSESSMENT

Please list all medications (prescription and over-the-counter) and vitamins, supplements, and herbs you are currently taking.

Today's Date	MEDICATIONS (Rx & OTC)	Dose	Frequency	Rx	Purpose	Date Started
				<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"/>		

Today's Date	VITAMINS, SUPPLEMENTS, & HERBS	Dose	Frequency	Rx	Purpose	Date Started
				<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"/>		

ALLERGIES: Please list allergies to medications, foods, pollens, metals, etc.

OTHER: I **do / do not** (*circle one*) have a pacemaker.

I **do / do not** (*circle one*) have a bleeding disorder.

Are you or could you be pregnant? **Yes / No**



Indicate any symptoms you have now or have had recently.

WOOD (LR/GB)

- Craving sour food
- Anger
- Irritability
- Difficulty making decisions
- Depression
- Feeling of lump in throat
- Teeth clenching at night
- Frequent sighing or yawning
- Pain under ribs
- Headaches / migraines
- Dizziness
- Spots in front of eyes
- Red eyes
- Dry or itchy eyes
- High blood pressure
- Low blood pressure
- Light sensitivity
- Blurred vision
- Bitter taste in mouth
- Blushing
- Muscle twitch or cramping
- Joint stiffness or pain
- Cold hands or feet
- Soft or brittle nails

FIRE (HT/SI)

- Craving bitter food
- Lack of joy
- Anxiety
- Restlessness
- Agitation
- Laughing for no reason
- Easily startled
- Palpitations
- Chest pain
- Difficulty falling asleep
- Wake up a lot or toss & turn
- Vivid or disturbing dreams
- Feel hot easily

WATER (KI/BL)

- Craving salty food
- Fear
- Lack of willpower
- Ringing in ears
- Hearing problems
- Poor memory
- Hair loss
- Aching bones
- Weak/pain in low back/knee
- Cold in low back / knees
- Feel cold easily
- Frequent or urgent urination
- Incontinence
- Wake up >2x to urinate
- Night sweats
- Hot flashes
- Low sexual desire
- High sexual desire

METAL (LU/LI)

- Craving spicy food
- Sadness / grief
- Shortness of breath
- Dry cough
- Cough with phlegm
- Runny nose
- Itchy, red or painful throat
- Nosebleeds
- Dry mouth
- Skin rash
- Itchy skin
- Dry skin or hair
- Sweating easily
- Allergies
- Frequent colds >2 per year
- Mild fever on & off
- Cramps with BM
- Unsatisfying BM
- Burning with BM

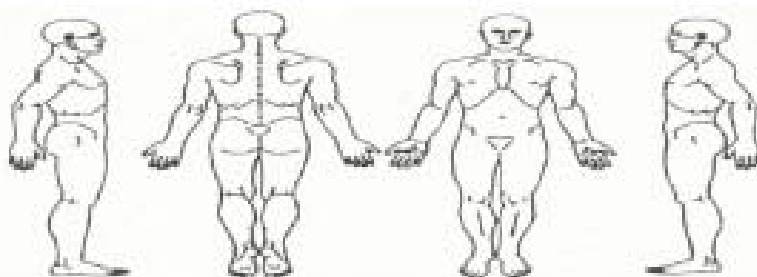
EARTH (SP/ST)

- Craving sweet food
- Over-thinking / obsessive
- Worry a lot
- Fatigue
- Low appetite
- Abdominal pain
- Tiredness after eating
- Loose stool or diarrhea
- Constipation
- Bruise easily
- Hemorrhoids
- Prolapse or hernia
- Nausea
- Vomiting
- Belching or hiccups
- Reflux or heartburn
- Bad breath
- Excessive hunger
- Ulcer or gastritis
- Body heaviness
- Edema (swelling)
- Gas or bloating
- Foggy mind

DIET AND LIFESTYLE

- Thirsty and drink cold
- Thirsty but don't drink
- Thirsty and drink warm
- Not thirsty
- Poor diet
- Consume caffeine daily
- Smoke or chew tobacco
- Drink alcohol
- Use street drugs
- Too little exercise / activity
- Exercise excessively
- Eating disorder
- Job stress / concerns
- Family stress / concerns
- Other stress / concerns
- Average # hours sleep _____
- Total # meals per day _____
- Special diet:
 - Low fat
 - Low salt
 - Low cholesterol
 - Gluten free
 - Lactose intolerant
 - Vegetarian
 - Vegan
 - Other: _____

Indicate areas of pain, numbness, and tingling below.





WOMEN'S HEALTH HISTORY

GENERAL GYNECOLOGY

How often would you want to have intercourse if it were up to you? _____

- Chronic vaginal discharge
- Recurring yeast infections
- Vaginal dryness
- Breasts lumps / nodules
- Mastitis
- Cysts
- Endometriosis
- Pelvic abnormalities / adhesions
- Fibroids
- PID
- Abnormal pap smear
- Uterus or bladder prolapsed
- Hysterectomy
- STDs _____
- Others _____

REPRODUCTIVE HISTORY

Are you currently using birth control? Y / N

Are you trying to conceive? Y / N

Are you currently lactating? Y / N

How many pregnancies have you had? ____

How many children do you have? ____

How many abortions have you had? ____

How many miscarriages have you had? ____

Have you had any:

- High-risk pregnancies
- Difficult labor / deliveries
- Postpartum concerns
- Lactation concerns

MENOPAUSE

Are you currently menopausal? Y / N

What month/year was your last period? _____

Do you currently have any:

- Night sweats
- Hot flashes (daytime)
- Vaginal dryness
- Spotting
- Depression
- Other: _____
- Other: _____

SKIP THIS COLUMN IF NO LONGER GET PERIODS

MENSTRUATION

Age when menses began _____

Menstruation lasts _____ days

Regular cycle of _____ days from period to period

Irregular cycle of ____ to ____ days

Can you tell when you ovulate? Y / N / sometimes

During your period, the flow is:

- Light/spotting on days _____
- Medium on days _____
- Heavy on days _____
- Spotting between periods

What color is the blood?

- Clots on days _____
- Light red on days _____
- Bright red on days _____
- Dark red on days _____
- Purple on days _____
- Brown on days _____
- Black on days _____

PMS

- Mood fluctuations
- Sadness or weeping
- Irritability or anger
- Breast changes
- Headache
- Cramps or backache
- Fatigue
- Nausea
- Acne

AFTER MENSTRUATION

- Dizziness
- Fatigue
- Insomnia
- Night sweats
- Other _____