Beautiful Ama
Acupuncture for Whole Body Health

Ama Acupuntura
Clínica de Acupuntura y Naturismo

PATIENT INFORMATION

THANK YOU FOR CHOOSING BEAUTIFUL AMA!
We are excited to work with you to balance your body and emotions naturally. These questions will help us develop an individualized diagnosis and treatment plan just for you.

Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

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

E-mail Address _____ We do NOT share your email with anyone.

Date of Birth _____ Age _____ Weight _____ Height _____ Gender: M / F

Employer _____ Occupation _____

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Committed relationship
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Children (with their ages): _____

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

Health Insurance: BlueCross PreferredOne Aetna HealthPartners Medica Other:_____

Health Savings Account (HSA)? Yes / No Flexible Spending Account (FSA)? Yes / No

Itex member? Yes / No Itex member number? _____

Have you ever received acupuncture before? Yes / No When? _____ How was it? _____

How did you hear about us? _____

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

Are you interested in getting more information on cosmetic acupuncture for anti-aging? Yes / No

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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
- ☐ Massage Therapist
- ☐ Physical Therapist
- ☐ Dietitian / Nutritionist
- ☐ Psychotherapist
- ☐ Psychiatrist
- ☐ Cranio-Sacral Therapist
- ☐ Other: _____
- ☐ Other: _____

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:

- ☐ Asthma
- ☐ Seizures
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart Attack
- ☐ Anemia
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Substance Addiction
- ☐ Depression
- ☐ Anxiety
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ STD:_____

Family medical history (parents, siblings, grandparents)

_____
_____
_____

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PATIENT RISK ASSESSMENT

Please list all medications, vitamins, supplements, and herbs you are taking.

Today's Date	MEDICATIONS (Rx & OTC)	Dose	Frequency	Rx	Purpose	Date Started

Today's Date	VITAMINS, SUPPLEMENTS, & HERBS	Dose	Frequency	Rx	Purpose	Date Started

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**

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Indicate any symptoms you have now or have had in the last month.

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

FIRE (HT/SI)
- □ Craving bitter food
- □ Lack of joy
- □ Anxiety
- □ Restlessness
- □ Agitation
- □ Easily startled
- □ Palpitations
- □ Chest pain
- □ Difficulty falling asleep
- □ Wake up a lot or toss & turn
- □ Vivid or disturbing dreams
- □ Feel hot easily

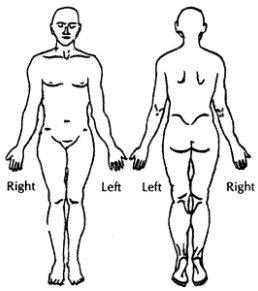
WATER (KI/BL)
- □ Craving salty food
- □ Fear
- □ Lack of willpower
- □ Ringing in ears
- □ Hearing problems
- □ Poor memory
- □ Hair loss
- □ Aching bones
- □ Weak/pain in low back/knee
- □ Cold in low back / knees
- □ Feel cold easily
- □ Frequent urination
- □ Urgent urination
- □ Incontinence
- □ Recurring bladder infections
- □ Wake up >2x to urinate
- □ Night sweats
- □ Hot flashes
- □ Low sexual desire
- □ High sexual desire
- □ MEN: enlarged prostate

METAL (LU/LI)
- □ Craving spicy food
- □ Sadness or grief
- □ Shortness of breath
- □ Dry cough
- □ Cough with phlegm
- □ Runny nose
- □ Sinus problems
- □ Itchy, red or painful throat
- □ Nosebleeds
- □ Dry mouth
- □ Skin rash
- □ Itchy skin
- □ Dry skin or hair
- □ Sweating easily
- □ Allergies
- □ Frequent colds >2 per year
- □ Cramps with bowel movements
- □ Unsatisfying bowel movements
- □ Burning with bowel movements

EARTH (SP/ST)
- □ Craving sweet food
- □ Over-thinking or obsessive
- □ Worry a lot
- □ Fatigue
- □ Low appetite
- □ Abdominal pain
- □ Tiredness after eating
- □ Loose stools or diarrhea
- □ Constipation
- □ Bruise easily
- □ Hemorrhoids
- □ Prolapse or hernia
- □ Nausea
- □ Vomiting
- □ Frequent belching
- □ Frequent hiccups
- □ Reflux or heartburn
- □ Bad breath
- □ Excessive hunger
- □ Ulcer or gastritis
- □ Recurring yeast infections
- □ Body heaviness
- □ Edema (swelling)
- □ Gas
- □ Bloating
- □ Foggy mind

DIET AND LIFESTYLE
- □ Thirsty and drink cold
- □ Thirsty but don't drink
- □ Thirsty and drink warm
- □ Not thirsty
- □ Poor diet
- □ Caffeine _____
- □ Smoke or chew tobacco
  - ⑥ Want to quit? Yes / No
- □ 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:
  - ⑥ Low fat
  - ⑥ Low cholesterol
  - ⑥ Gluten-free
  - ⑥ Dairy-free
  - ⑥ Vegetarian
  - ⑥ Vegan
  - ⑥ Other:_____

Indicate areas of pain, numbness, and tingling below.



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WOMEN'S HEALTH HISTORY

GENERAL GYNECOLOGY

If you'd like to talk about sexual desire:
How often would you currently 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 YOU ARE NO LONGER HAVING 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 tenderness
- ☐ Headache
- ☐ Cramps
- ☐ Back pain
- ☐ Fatigue
- ☐ Nausea
- ☐ Acne
- ☐ Frequent bowel movements
- ☐ Diarrhea

AFTER MENSTRUATION

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