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 _____

What do you prefer to be called (nickname)? _____

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): _____ How many live at home? _____

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

Are you interested in getting more information on ayurveda (holistic medicine from India)? 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:

- ☐ Ayurveda Practitioner
- ☐ Massage Therapist
- ☐ Chiropractor
- ☐ Physical Therapist
- ☐ Psychotherapist
- ☐ Psychiatrist
- ☐ Cranio-Sacral Therapist
- ☐ Dietitian / Nutritionist
- ☐ 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)

Other issues that are important about your health history

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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LIFESTYLE HISTORY

ROUTINES AND PERSONALITY

How busy is your lifestyle? Workaholic Overscheduled No downtime Balanced Too much downtime
Do you like having a routine? Yes / No Are you attached to how you do things? Yes / No
Do you generally follow through on things? Yes / No Do you feel overwhelmed easily? Yes / No
Are you organized? Yes / No Do you keep lists? Yes / No Difficulty making decisions? Yes / No

WORK HISTORY

What kind of work do you currently do? _____
What kind of work have you done in the past? _____

SUBSTANCES

Did you ever smoke cigarettes? Yes / No Chew tobacco? Yes / No Smoke marijuana? Yes / No
How much per day? _____ For how long? _____ If quit, what year? _____
Alcohol use (per week): _____ Caffeine use (per week): _____ Soda (per week): _____
Do you have any other addictions to substances? Yes / No Which substances? _____

SLEEP AND ENERGY

How many hours do you sleep per night? _____ How many hours of sleep do you feel best with? _____
Sleep quality? Excellent Good Fine Bad Terrible Are you a light sleeper? Yes / No
Do you like to stay up late? Yes / No Do you get a second wind after 10 pm? Yes / No
How many times per night do you wake up? _____ If wake up, is it hard to fall back asleep? Yes / No
Difficulty falling asleep? Yes / No Toss and turn? Yes / No Wake up too early? Yes / No
Do you have vivid dreams? Yes / No Nightmares? Yes / No Excessive dreams? Yes / No
Sleep issues? Teeth clenching Snoring Talking in sleep Waking suddenly Sleep apnea Sleepwalking

What time do you go to bed? _____ What time fall asleep? _____ What time wake up? _____
Is your sleep schedule the same most of the time? Yes / No If not, why? _____
Is it hard to get up in the morning? Yes / No Do you feel rested in the morning? Yes / No
What time of day do you have the best energy? _____ What time of day is worst? _____
Overall how is your energy? Excellent Good Fine Bad Terrible I Have to Push Through

EMOTIONAL AND SPIRITUAL HEALTH

Do you have a lot of stress? Yes / No What types? Work Home Extended Family Other: _____
What kind of traumatic events have you had in your life (abuse, significant deaths, accidents, injuries, health conditions)? _____
How was your childhood? Anything significant? _____
How do you maintain your spiritual health? _____

How would you describe your emotions?

Fearful Anxious Worry a lot Overthinking Oversensitive Fluctuates Overwhelmed easily
Anger Irritability Frustrated Annoyed Impatient Critical Crabby Aggressive Road rage
Sadness Depression Grief Obsessive Subdued Unmotivated Indecisive Unfocused
Calm Happy Joyful Peaceful Even-tempered

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DIGESTION HISTORY

NUTRITION

Are you on a special diet?

- ☐ Gluten free
- ☐ Dairy free
- ☐ Nut free (Allergy? Yes / No)
- ☐ Low carb
- ☐ Low salt
- ☐ Low cholesterol
- ☐ Vegetarian
- ☐ Vegan
- ☐ Other: _____

Do you have food sensitivities? Yes / No Which foods? _____

How healthy is your overall diet and nutrition? Excellent Good Fine Bad Terrible

Do you have any of these disordered eating patterns? Overeating Obsessing Anorexia Bulimia

How is your appetite? Excessive Steady Low Irregular Sudden hunger

Do you feel thirsty? Yes / No Which beverages do you prefer? Iced Cold Room Temp Warm Hot

Do you drink pop / soda or energy drinks? Yes / No How many per day? _____ soda / energy

How many times a day do you eat? _____ Do you feel tired after eating? Yes / No

What flavors of food do you crave? Sweet Salty Sour Pungent/Spicy Bitter Astringent

What kinds of foods do you crave? _____

How often do you eat the foods that you crave? _____

What are your meal-time habits? _____ Regular meals Irregular meals

Describe typical meals for you:

☐ Breakfast:		Time:
☐ Lunch:		Time:
☐ Dinner:		Time:
☐ Snacks:		Time:

BOWEL MOVEMENTS

Which digestion issues do you have? Gas Bloating Pain Burping Bad breath Nausea Heartburn Reflux

How often do you have bowel movements? 1x/day 2-3x/day >3x/day every 2-3 days weekly

What time of day? Morning Many times in morning Afternoon Evening Bedtime Throughout day

What are your stools like? Urgent Loose Diarrhea Dry Pellets Strands Like mud Like banana

Do your stools have a strong odor? Yes / No What do your stools do? Float Sink Stick to bowl

Do you feel these with bowel movements? Bloating Cramping Burning Incomplete

Do you have hemorrhoids? Yes / No

WEIGHT LOSS

Have you lost weight in the past? No Yes (how much? _____ pounds, how? _____)

Do you want to lose weight in the future? No Yes (how much? _____ pounds)

If you want to lose weight, how committed are you? Actively trying Trying to get motivated Just hoping

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SYSTEMS HISTORY

HAIR, SKIN, AND NAILS

Do you have any skin issues? Dry skin Itchy skin Oily skin Acne Eczema Rashes Bumps
How is your hair? Dry hair Brittle hair Greasy hair Hair loss
How are your nails? Strong Soft Split easily Ridges Excessive cuticles Cracking cuticles
Do you bruise easily? Yes / No Do you bleed easily? Yes / No

EYES, EARS, AND MOUTH

Do you have eye issues? Red eyes Dry eyes Itchy eyes Blurry vision Light sensitive Black spots in vision
Do you have ear issues? Tinnitus (ringing in the ears) Hearing problems Ear infections
Do you have mouth issues? Dry mouth Bitter taste Metallic taste Canker sores
Do you have throat issues? Feeling of lump in throat Itchy throat Red throat Painful throat

SINUSES AND IMMUNE SYSTEM

Do you have sinus issues? Yes / No Runny nose? Yes / No Stuffy nose? Yes / No
Seasonal allergies? Yes / No Post-nasal drip? Yes / No Nosebleeds? Yes / No
Frequent colds (>2x/year)? Yes / No Sinus infections? Yes / No

TEMPERATURE

Are you sensitive to temperatures and have a small range of comfortable temperatures? Yes / No
Do you get cold easily? Yes / No Do you usually wear these? Layers Scarves Bring sweater
Do you get hot easily? Yes / No Do you have hot flashes? Yes / No Do you flush easily? Yes / No
Do you frequently have any of these? Cold hands Cold feet Circulation issues
How is your sweating? Normal Excessive sweating Difficulty sweating Night sweating

CHEST, HEART, AND LUNGS

Chest issues? Chest pain Chest tightness Shortness of breath Frequent sighing Frequent yawning
Heart issues? Palpitations High blood pressure Low blood pressure High cholesterol Low cholesterol
Do you have chronic cough? Dry cough Cough with thin phlegm Cough with yellow phlegm

MIND AND NEUROLOGICAL

Do you have any of these issues? Poor memory Easily startled Lack of willpower
Do you have any of these issues? Foggy mind Lack of motivation Hard to focus Hard to concentrate
Do you have any issues with dizziness? Dizziness Off balance Walk crooked Lose balance easily
Do you have tremors? Yes / No Where do you have tremors? Head Hand Body

URINATION

How is your urination? Normal Urgency Frequency
Do you have any urination issues? Bladder infections Incontinence Stress Incontinence (laugh / cough)
MEN: Do you have Benign Prostate Hypertrophy (BPH or enlarged prostate)? Yes / No / Don't Know
MEN: Do you have urination symptoms? Frequent urination Urgent urination Painful urination
Incomplete emptying Dribbling afterwards Burning urination
Difficulty starting to urinate Weak flow of urine Incontinence

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PAIN HISTORY

HEADACHES

Do you get headaches? Yes / No How often? _____ Triggers? _____
Location? Forehead Behind eyes Back of neck Temples Top of head Side of head
Type of headache? Sinus Tension Dull Throbbing
Do you get migraines? Yes / No How often? _____ Triggers? _____
Symptoms with migraines? Nausea Vomiting Light sensitivity Sound sensitivity

ACUTE PAIN

Do you have any recent pain that you would like us to know about? Yes / No Where? _____
When did it start? _____ How did it start? _____
Pain level (1-10, with 10 being worst): _____

CHRONIC PAIN

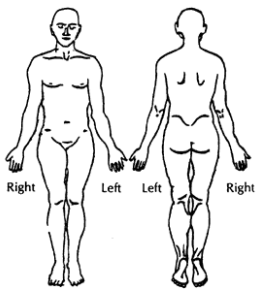
Do you have chronic pain issues? Yes / No Any diagnosis? Arthritis Fibromyalgia Hypermobile Joints
What type of pain? Aching bones Muscle pain Joint pain Weakness Stiffness
Describe the pain: Moves around Fixed Aching Sharp Dull Stiffness Swelling Burning
Where do you have pain? Neck Upper Back Shoulders Mid-back Low back Hip Side of ribs
Knee Ankle Foot Elbow Wrist Hand
Pain level (1-10, with 10 being worst): _____

Do you have any of these issues? Swelling Numbness Tingling Altered sensation Burning sensation
Do you have joints that makes noises like popping or cracking? Yes / No Where? _____
Muscle issues? Cramping Weakness Stiffness Do you have edema (water swelling)? Yes / No

PAIN TREATMENT

What makes your pain better? Heat Ice Resting Exercising Stretching Warm weather
What makes your pain worse? Heat Ice Resting Exercising Stress Damp weather

Indicate areas of pain, numbness, and tingling below.



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SEXUAL DESIRE (MEN & WOMEN)

How would you describe you sexual desire? Very low Low Medium High Excessive
How do you feel about your level of sexual desire? Would like more It's fine Would like less
How often would you have intercourse if it were up to you? _____ times per _____
How important is it for you to address issues in your sex life? Very important Somewhat Not a priority
How do you feel about your sex life? _____

MEN'S HEALTH HISTORY

Please make sure you answered the prostate & urination questions in the Urination section.
Do you have any symptoms that concern you? Testicle pain Lumps Hard areas Pain during intercourse
Any issues with erections? Difficulty getting erection Difficulty maintaining erection Pain during erection
Any issues with ejaculation? Difficulty ejaculating Ejaculate too easily

WOMEN'S HEALTH HISTORY

REPRODUCTIVE SYSTEM ISSUES

Do you have these symptoms? Chronic vaginal discharge Vaginal dryness Recurring yeast infections
Have you had a hysterectomy? Yes / No Do you have any breast issues? Lumps or nodules Mastitis
Do you have any gynecological issue? Cysts Endometriosis Fibroids Pelvic floor issues
Have you ever had an abnormal pap smear? Yes / No When was it? _____
Have you ever had a sexually transmitted infection (STI)? Yes / No Which one and when?_____
Do you have any other issues? Uterus prolapse Bladder prolapse Other: _____

BIRTH CONTROL AND PREGNANCY

Are you currently using birth control? Yes / No Which kind? _____
Are you trying to conceive? Yes / No Are you currently lactating? Yes / No
How many pregnancies have you had? _____ Children? _____ Miscarriages? _____ Abortions? _____
Have you had any of these? High-risk pregnancies Difficult labor / deliveries Postpartum concerns

MENOPAUSE

Are you menopausal? Yes / No When was your last period? _____ Have these?
Do you have menopause symptoms? Night sweats Hot flashes Vaginal dryness Spotting Depression

PERIODS (Skip this section if you are menopausal)

How old were you when period started? _____ Do you know when you ovulate? Yes / No / Sometimes
Are your periods regular? Yes / No How many days is your cycle (period to period)? _____to_____ days
How many days do you bleed for? _____ days Do you have spotting between periods? Yes / No
How heavy is the flow? Light/spotting on days _____ Medium on days _____ Heavy on days _____
What color is the blood? Light red Bright red Dark red Purple Brown
Do you have clots? Not sure Not really Some clots Many clots
How strong is your PMS? Not much Mild Medium Bad When does PMS start? _____ before period
Which PMS symptoms do you get?

Cramps	Headaches	Mood fluctuations	Loose stools
Back pain	Migraines	Cry easily	Breast tenderness
Fatigue	Acne	Irritability	Nausea