nature's touch healing center

Acupuncturists

Monica Mathews, LAc.
Cynthia Conlin, LAc.

Name (Last, First) _____ **Date:**_____
Address_____
City/State, Zip Code_____
Phone Numbers: ***Home***_____ ***Cell***_____ ***Work***_____
Is it ok to leave a message on an answering machine? ☐ **Yes** ☐ **No**
Email:_____ **May I contact you via email?** ☐ **Yes** ☐ **No**
Emergency Contact Name:_____ **Phone:**_____
How did you find out about the clinic? _____

Health Information:

Sex:_____ **Height:**_____ **Weight:**_____ **Birth Date:**_____ **Age:**_____
Have you experienced Acupuncture before? ☐ **Yes** ☐ **No**

Medications and Supplements:

_____
_____
_____
_____
_____

Are you under another practitioners care? _____
For what condition(s)? _____
_____
What is our focus for today? _____
_____
What other forms of treatment have you sought? _____
_____
List any allergies: _____
_____
Please list hospitalizations, surgeries or accidents: _____
_____
_____
_____

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Please indicate any diseases you or a blood relative now have or have had in the past:

Illness	You	Relative
Cancer		
Hepatitis		
High Blood Pressure		
Rheumatic Fever		
Diabetes		
Heart Disease		
Seizures		
Emotional Disorders		
Tuberculosis		
STD's		
Herpes		
HIV/Aids		
Bleeding Disorder		

Please indicate usage and frequency of the following:

	Yes	No	How Often
Coffee			
Alcohol			
Recreational Drugs			
Tobacco			
Soda			
Water Intake			

For Men:

Date of last prostate exam: _____ PSA Results:_____

Frequency of Urination: Daytime _____ Night time _____

Color of Urine: _____ Is there a strong odor? _____

Circle any prostrate symptoms you are experiencing:

Rectal dysfunction	**Back pain**	**Groin pain**	**Delayed Stream**
Dribbling	**Incontinence**	**Urine retention**	**Impotence**
Premature Ejaculation	**Testicular pain**	**Other_____**	

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For Women:

Are you pregnant? ☐ Yes ☐ No Age of 1st Period:_____ Age of last Period:_____
# of pregnancies:____ # of live births:____ # of abortions:____ # of miscarriages:_____
# of days between periods:____ # of days of flow:____ Color of flow:_____
Clots: ☐ Yes ☐ No Flow is: Light ☐ Medium ☐ Heavy ☐
Date of Last: Pap_____ Mammogram_____ Bone Density_____
Irregular results:_____

Circle any that apply:

Fibroids Fibrocystic Breasts Ovarian Cysts PID Endometriosis

Circle symptoms experienced related to your menstrual cycle:

Discharge	**Vaginal Dryness**	**Headache**	**Nausea**
Constipation	**Diarrhea**	**Swollen Breasts**	**Tender Breasts**
Mood Swings	**Inc. Appetite**	**Dec. Appetite**	**Hot Flashes**
Night Sweats	**Inc. Libido**	**Dec. Libido**	**Insomnia**
Bloating	**Cramping**	**Bearing down sensation**	

Any other symptoms not listed above:

_____
_____
_____

Symptom Survey for Everyone:

The following is a list of symptoms that you may or may not experience. Please indicate a check mark next to the symptoms you sometimes experience and a + sign by the symptoms you experience frequently. These groupings are broken up into elements. This will help us together find out which elements are out of balance and to create a treatment plan for you.

Earth

____ lack of appetite	____ excessive appetite	____ vomiting	____ loose stool/diarrhea
____ nausea	____ heartburn/reflux	____ burping	____ food "sits" in stomach
____ hemorrhoids	____ bruising	____ fatigue after eating	____ foggy thinking
____ tendency to obsession in work/relationships			

Fire

____ insomnia	____ heart palpitations	____ nightmares	____ mental restlessness
____ angina	____ chest tightness	____ anxiety	____ laughing for no reason
____ vivid dreams			

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Metal

____ cough	____ grief	____ constipation	____ nasal congestion
____ rashes	____ bronchitis	____ diverticulitis	____ colitis
____ claustrophobia	____ anxiety	____ asthma	____ shortness of breath
____ decreased sense of smell			

Water

____ low back pain	____ knee problems	____ ear ringing	____ hearing loss
____ kidney stones	____ hair loss	____ decreased sex drive	____ urinary problems
____ incontinence	____ osteoporosis	____ hot flashes	____ night sweats
____ early morning diarrhea			

Wood

____ eye problems	____ jaundice	____ gall stones	____ soft nails
____ brittle nails	____ sighing	____ light colored stools	____ easily angered
____ liver disease	____ spasms or twitching	____ tics	____ high blood pressure
____ migraines	____ hiccups	____ high cholesterol	____ anger
____ difficulty digesting oily foods		____ difficulty making decisions	

Blood and Qi

____ Fatigue	____ Edema	____ Blood in stool	____ Black stool
____ Bruising	____ Dizziness	____ Allergies	____ Hay fever
____ Frequent colds	____ Sudden weight loss	____ Dry skin	____ Dry hair
____ Cold hands and feet	____ Poor memory	____ Floaters in vision	
____ Hair thinning/falling out		____ Interolerance to weather changes	

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