integrative
Chiropractic & Natural Medicine

Acupuncture Exam

Name ____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations. Use the numbers to describe how your pain has affected your life
1-None, 2-Little, 3-Moderate, 4-Often, 5-Constant

Pain Intensity Levels
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Sleeping
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Work – Can do:
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

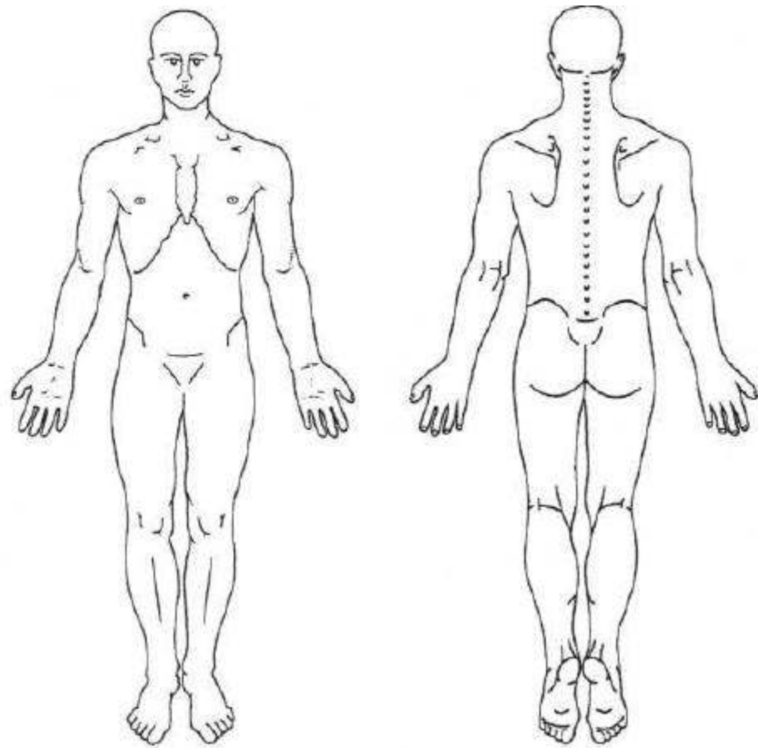
Frequency of Pain
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Travel
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Recreation – Can do:
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Walking
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Sitting
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5



Medical History

Do you have any allergies? ◯ Yes ◯ NO If so, to what? ______________________________

Do you take medication? ◯ Yes ◯ NO If so, what type and how much? ______________________________

Do you take supplements? ◯ Yes ◯ NO If so, What type and how often? ______________________________

Do you sleep well? ◯ Yes ◯ NO Do you dream? ◯ Yes ◯ NO

Do you have a high point during the day? ◯ Yes ◯ NO When? ______________________________

Do you have a low point during the day? ◯ Yes ◯ NO When? ______________________________

Please indicate if you or any family members have or had any of the following conditions:

◯ Pneumonia	◯ Drug Reaction	◯ Mental Breakdown	◯ Gonorrhea/Herpes	◯ Mental Illness
◯ Tuberculosis	◯ Heart Attack	◯ Jaundice	◯ HIV/Aids	◯ Hypo/Hyper Thyroid
◯ Hepatitis	◯ Blood Transfusion	◯ Parasites	◯ High/Low Blood Pressure	◯ Premature Graying
◯ Diabetes	◯ Anemia	◯ Measles	◯ Heart Disease	◯ Seizures
◯ Epilepsy	◯ Arthritis	◯ Mumps	◯ Gout	◯ Multiple Sclerosis
◯ Kidney Stones	◯ Obesity	◯ Syphilis	◯ Cancer	

Female Concerns

Date of last menstruation ________________________

Is your cycle regular? ◯ Yes ◯ NO Is your cycle painful? ◯ Yes ◯ NO

Have you ever been pregnant? ◯ Yes ◯ NO Birth Control? ◯ Yes ◯ NO How Long?

◯ PMS ◯ Clotting ◯ Vaginal Sores ◯ Discharge Other? ____

Male Concerns

◯ Testicle Pain ◯ Penis Pain ◯ Penis Sores ◯ Discharge ◯ Impotence

◯ Nocturnal Emission ◯ Premature Ejaculation Other: ____

Signs / Symptoms

◯ Abdominal Pain	◯ Coughing Blood	◯ Hemorrhoids	◯ Muscle Cramps	◯ Sinus Pressure
◯ Abuse Survivor	◯ Dark Stool	◯ Heart Palpitations	◯ Nasal Congestion	◯ Skin Fungal Infection
◯ Acid Regurgitation	◯ Decreased libido	◯ Hiccup	◯ Neck/shoulder pain	◯ Spot in eyes
◯ Acne	◯ Depression	◯ High blood pressure	◯ Night sweat	◯ Sweat easily
◯ Asthma	◯ Dizziness/vertigo	◯ Increased Libido	◯ Nose bleeds	◯ Sore throat
◯ Bad Breath	◯ Dry throat/mouth	◯ Indigestion	◯ Numbness	◯ Sudden energy drop
◯ Blood in Stool	◯ Diarrhea	◯ Intestinal pain	◯ Odorous stools	◯ Swollen glands
◯ Blood in Urine	◯ Ear Aches	◯ Irritable	◯ Pain upon urination	◯ Teeth/gum problems
◯ Blurry Vision	◯ Enlarged thyroid	◯ Itchy Eyes	◯ Peculiar tastes	◯ Ulcerations
◯ Breast Lump/pain	◯ Eye pain/strain/tension	◯ Itchy skin	◯ Poor appetite	◯ Upper back pain
◯ Bruise Easily	◯ Excessive Phlegm Color of:	◯ Join pain	◯ Poor circulation	◯ Urgent urination
◯ Chest Pains		◯ Kidney stones	◯ Poor memory	◯ Vomiting
◯ Chills	◯ Excessive Saliva	◯ Laxative use	◯ Poor sleep	◯ Wake to urinate
◯ Cold hands/feet	◯ Fatigue	◯ Limited range of motion	◯ Psoriasis	◯ Weight loss/gain
◯ Concussion	◯ Fever	◯ Loss of hair	◯ Rash	◯ Wheezing
◯ Confusion	◯ Frequent Urinating	◯ Low back pain	◯ Redness of eyes	◯ Other: ____________
◯ Constipation	◯ Gas/Belching	◯ Migraine	◯ Seizures	____________
◯ Cough	◯ Grinding Teeth	◯ Mouth sores	◯ Short temper	____________
	◯ Headache	◯ Mucus in stool	◯ Shortness of breath	____________

Signature: ____ Date: ____________________