Your First Visit

Generally, your first visit is longer than your follow up visits or at the very least it entails quite a bit of questioning. Some practitioners will not treat at all on the first visit. In my practice, after initial questioning, I always begin with a gentle balancing treatment to address your specific concerns.

The initial questioning is a very important part of the care that I can provide to you. While many of the questions may seem entirely irrelevant to your condition, for example asking the quality of your bowel movements when you came in for back pain or your psychological state when you came in for menstrual problems, there are very good reasons behind the questions. The answers you provide to the questions, along with other basic diagnostic tools such as looking at your tongue and feeling your pulse allow me to tailor the treatment specifically to you.

In general people find acupuncture to be an incredibly relaxing experience, even for those who have some initial hesitation about needles. The needling during the first treatment may be limited so you can become accustomed to the experience and the practitioner can see how you respond.

This individualization of the treatments is one of the strong points of oriental medicine. It is why people may experience broad changes within themselves after receiving acupuncture for a specific complaint. It also means that the treatments can be modified over time if they are not proving effective.

LYNNE MARTIN ACUPUNCTURE

////////////////////// Personal and Confidential Information //////////////////////

Name_____ Date_____
Home Address _____
City _____ State_____ Zip _____
Home Phone_____ Cell Phone _____ Work Phone_____
Gender _____ Height _____ Weight _____ Birthday _____ Age _____
Marital Status _____ Number of Children _____
EMAIL _____ Occupation _____

Who should we thank for referring you to this office? _____
When was your last acupuncture visit? _____ With whom? _____

What is the MAIN REASON for your visit today? _____
_____

Onset? _____ Other therapies? _____

Other health problems? _____

Allergies _____

Food Cravings? _____

Medical History

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer				Diabetes			
Hepatitis				Heart Disease			
Emotional Disorders				Infectious Disease			
High Blood Pressure				Seizures			

Please Circle any of the following you may have:
Gonorrhea/ Syphilis/ AIDS/ Herpes/ HPV/ Chlamydia. When contracted? _____

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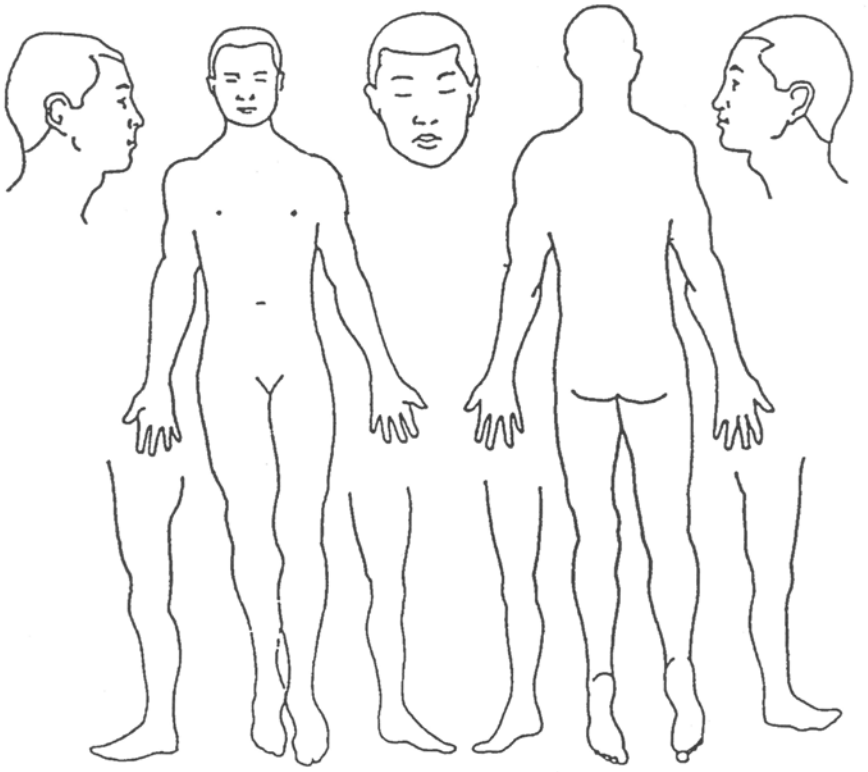
On the following drawing, SHADE in the areas that you feel should be addressed.



Significant Medical Events

Describe any significant **injuries**, **surgeries**, or major **illnesses**, **scars,** whether **hospitalized** or not, and the dates:

_____ _____

_____ _____

_____ _____

_____ _____

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Please list medications or supplements you are currently taking? (continue on back)

Medicine	Reason	How Long

////////////////////////////////For Women////////////////////////////////

Are you Pregnant? _____ # of Pregnancies _____
# of live births _____ # of abortions _____ # of miscarriages _____
Age of menarche _____ Age of menopause _____
# of days in cycle _____ # of days of blood flow _____
Amount of blood flow? Excess __ Moderate __ Slight __
Color of flow? Fresh red ___ Dark red ___ Pale red ___ Purple ___ Brown ___
Clots? _____ Clot size _____
Pain with period? Before ___ During ___ After ___
Nature of pain? Sharp/ Stabbing/ Burning/ Dull / Bloated/ Constant/ Intermittent
Location of pain? _____ (low ab, low back, thighs…)

Symptoms related to your cycle (Circle):
Yeast infections/ Vaginal Dryness/ Nausea/ Swollen Breasts/ Appetite Change/ Mood Swings/ Hot Flashes/ Night Sweats/ Libido Changes/ Headache/ Diarrhea/ Constipation/ Insomnia/ Dizziness/ Other _____

Have you been diagnosed with (Circle):
Fibroids/ Fibrocystic Breasts/ Endometriosis/ Ovarian Cysts/ PID

Results and Dates of last:
PAP Smear _____ Bone Density Scan _____ Mammogram _____

//////////////////// For Men ////////////////////

Frequency of Urination: Daytime _____ Nighttime _____
Date of last prostate exam _____ results _____ PSA results _____
Do you experience any of the following symptoms related to the prostate:
Groin pain/ rectal dysfunction/ back pain/ delayed stream/ dribbling/ incontinence/ urine retention/ libido change/ premature ejaculation/ impotence/ testicular pain/ Other _____

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//////////////////////////Symptom Survey ////////////////////////////////
Please indicate if you experience sometimes (√) or frequently (+)

__ lack of appetite
__ excessive appetite
__ soft stool
__ diarrhea
__ constipation
__ # of bowel movements per day
__ flatulent/bloated
__ nausea
__ vomiting
__ burping
__ heartburn/ reflux
__ food retention
__ obsessive thoughts
__ anxiety
__ abdominal pain
__ fatigue after meals
__ edema
//////////////////////
__ difficulty falling asleep
__ depression
__ nightmares
__ awaken frequently
__ mentally restless
__ heart palpitations
__ angina pains
__ chest pains
__ claustrophobia
__ low back pain
__ knee pain
__ ear ringing
__ hearing impaired
__ kidney stones
__ urinary pain
__ decreased sex drive
__ hair loss
__ hotflashes/ nightsweats
__ cold hands/feet
//////////////////////////
__ dry/crusty eyes
__ night blindness
__ brittle nails
__ irritability
__ mood swings
__ muscle twitches
__ headache/migraines
__ genital discomfort
__ jaundice
__ gall stones
__ light colored stool
__ fatigue/low energy
__ blood in stool
__ black tarry stool
__ easily bruised
__ dizziness
__ vertigo
__ asthma
__ frequent colds
__ intolerance to weather changes
__ aversion to cold
__ aversion to hot
__ allergies
__ hay fever
__ high cholesterol
__ sudden weight loss
////////////////////////////////
__ cough
__ shortness of breath
__ decreased sense of smell
__ nasal problems
__ bronchitis
__ colitis/ diverticulitis
__ hemorrhoids
__ recent use of antibiotics
__ asthma
__ skin rashes
__eczema
__ thirst
__ no thirst
__ tmj/ jaw problems
__ dizziness
__ history of psychological, physical or sexual abuse

Please list the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffee				**Tobacco**				**Water**			
Drugs				**Alcohol**				**Soda**			