

# AcuCare

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Appointment Date:

## General Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Married Single Partner Divorced Widowed Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Referred By \_\_\_\_\_  
Family Physician \_\_\_\_\_ Contact # \_\_\_\_\_  
Have you had Acupuncture or Oriental medicine before? Yes No  
Are you presently under a doctor's care? Yes No Who and for what? \_\_\_\_\_  
Are there any other therapies which you are involved in? Who and for what? \_\_\_\_\_

## Focus

What is your primary reason for seeking care at our office? \_\_\_\_\_

What was the initial cause? \_\_\_\_\_

When did it begin? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

How does this problem interfere with your daily activities?  Work  Standing  Sexually  Other  
 Sleep  Emotional  Recreation  
 Walking  Relationships  Bending  
 Sitting  Social Life  Stretching

What have you done about this? \_\_\_\_\_

Are you interested in:  Pain Relief  Performance Care  Maintenance Care  Other  
 Preventative Care  Holistic Health  Stress Relief  
 Oriental Nutrition  Meridian Yoga  Herbal Therapy

What are your health goals? \_\_\_\_\_

List any past or future surgeries. \_\_\_\_\_

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) \_\_\_\_\_

List exercise and sport activities you have been or are currently involved in: \_\_\_\_\_

### Signs/Symptoms

- |   |   |   |   |   |
|---|---|---|---|---|
| <input type="radio"/> Abdominal pain/distention | <input type="radio"/> Coughing blood          | <input type="radio"/> Hemorrhoids             | <input type="radio"/> Mucous in stools      | <input type="radio"/> Seizures              |
| <input type="radio"/> Abuse survivor            | <input type="radio"/> Dark stools             | <input type="radio"/> Heart palpitations      | <input type="radio"/> Muscle cramps/pain    | <input type="radio"/> Seeing a therapist    |
| <input type="radio"/> Acid regurgitation        | <input type="radio"/> Decreased libido        | <input type="radio"/> Hiccup                  | <input type="radio"/> Nasal congestion      | <input type="radio"/> Short temper          |
| <input type="radio"/> Acne                      | <input type="radio"/> Depression              | <input type="radio"/> High blood pressure     | <input type="radio"/> Neck/shoulder pain    | <input type="radio"/> Shortness of breath   |
| <input type="radio"/> Asthma                    | <input type="radio"/> Dizziness/vertigo       | <input type="radio"/> Impotence               | <input type="radio"/> Night sweat           | <input type="radio"/> Sinus pressure        |
| <input type="radio"/> Bad breath                | <input type="radio"/> Dry throat/mouth        | <input type="radio"/> Increased libido        | <input type="radio"/> Nocturnal emission    | <input type="radio"/> Skin fungal infection |
| <input type="radio"/> Blood in stools           | <input type="radio"/> Diarrhea                | <input type="radio"/> Indigestion             | <input type="radio"/> Nose bleeds           | <input type="radio"/> Spots in eyes         |
| <input type="radio"/> Blood in urine            | <input type="radio"/> Ear aches               | <input type="radio"/> Intestinal pain/cramps  | <input type="radio"/> Numbness              | <input type="radio"/> Sweat easily          |
| <input type="radio"/> Blurry vision             | <input type="radio"/> Enlarged thyroid        | <input type="radio"/> Irritable               | <input type="radio"/> Odorous stools        | <input type="radio"/> Sore throat           |
| <input type="radio"/> Breast lump/pain          | <input type="radio"/> Eye pain/strain/tension | <input type="radio"/> Itchy eyes              | <input type="radio"/> Pain upon urination   | <input type="radio"/> Sudden energy drop    |
| <input type="radio"/> Bruise easily             | <input type="radio"/> Excessive phlegm        | <input type="radio"/> Itchy skin              | <input type="radio"/> Peculiar tastes       | <input type="radio"/> Swollen glands        |
| <input type="radio"/> Chest pains               | <input type="radio"/> Color of                | <input type="radio"/> Joint pain              | <input type="radio"/> Poor appetite         | <input type="radio"/> Teeth/gum problems    |
| <input type="radio"/> Chills                    | <input type="radio"/> Excessive saliva        | <input type="radio"/> Kidney stones           | <input type="radio"/> Poor circulation      | <input type="radio"/> Ulcerations           |
| <input type="radio"/> Cold hands/feet           | <input type="radio"/> Fatigue                 | <input type="radio"/> Laxative use            | <input type="radio"/> Poor memory           | <input type="radio"/> Upper back pain       |
| <input type="radio"/> Concussion                | <input type="radio"/> Fever                   | <input type="radio"/> Limited range of motion | <input type="radio"/> Poor sleep            | <input type="radio"/> Urgent urination      |
| <input type="radio"/> Confusion                 | <input type="radio"/> Frequent urination      | <input type="radio"/> Loss of hair            | <input type="radio"/> Premature ejaculation | <input type="radio"/> Vomiting              |
| <input type="radio"/> Constipation              | <input type="radio"/> Gas/belching            | <input type="radio"/> Low back pain           | <input type="radio"/> Psoriasis             | <input type="radio"/> Wake to urinate       |
| <input type="radio"/> Cough                     | <input type="radio"/> Grinding teeth          | <input type="radio"/> Migraine                | <input type="radio"/> Rash                  | <input type="radio"/> Weight loss/gain      |
|   | <input type="radio"/> Headache                | <input type="radio"/> Mouth sores             | <input type="radio"/> Redness of eyes       | <input type="radio"/> Wheezing              |

### 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  Vaginal pain  Discharge

### Medical History

Do you have any allergies? Yes No If so, to what? \_\_\_\_\_  
Do you take medication? Yes No If so what types and how often \_\_\_\_\_  
Do you take supplements? Yes No If so what types and how often \_\_\_\_\_

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

- |                                    |   |  |   |  |
|------------------------------------|---|--|---|--|
| <input type="radio"/> Pneumonia    | <input type="radio"/> Drug reaction     | <input type="radio"/> Mental breakdown | <input type="radio"/> Gonorrhea/Herpes        | <input type="radio"/> Cancer             |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Heart attack      | <input type="radio"/> Jaundice         | <input type="radio"/> HIV/Aids                | <input type="radio"/> Mental illness     |
| <input type="radio"/> Hepatitis    | <input type="radio"/> Blood transfusion | <input type="radio"/> Parasites        | <input type="radio"/> High/low blood pressure | <input type="radio"/> Hypo/hyper thyroid |
| <input type="radio"/> Diabetes     | <input type="radio"/> Anemia            | <input type="radio"/> Measles          | <input type="radio"/> Heart disease           | <input type="radio"/> Premature graying  |
| <input type="radio"/> Epilepsy     | <input type="radio"/> Arthritis         | <input type="radio"/> Mumps            | <input type="radio"/> Gout                    | <input type="radio"/> Seizures           |
| <input type="radio"/> Kidney Stone | <input type="radio"/> Obesity           | <input type="radio"/> Syphilis         |   | <input type="radio"/> Multiple Sclerosis |

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? \_\_\_\_\_

What are your indulgences? \_\_\_\_\_

What are your hobbies/pleasures? \_\_\_\_\_

### Web of Wellness

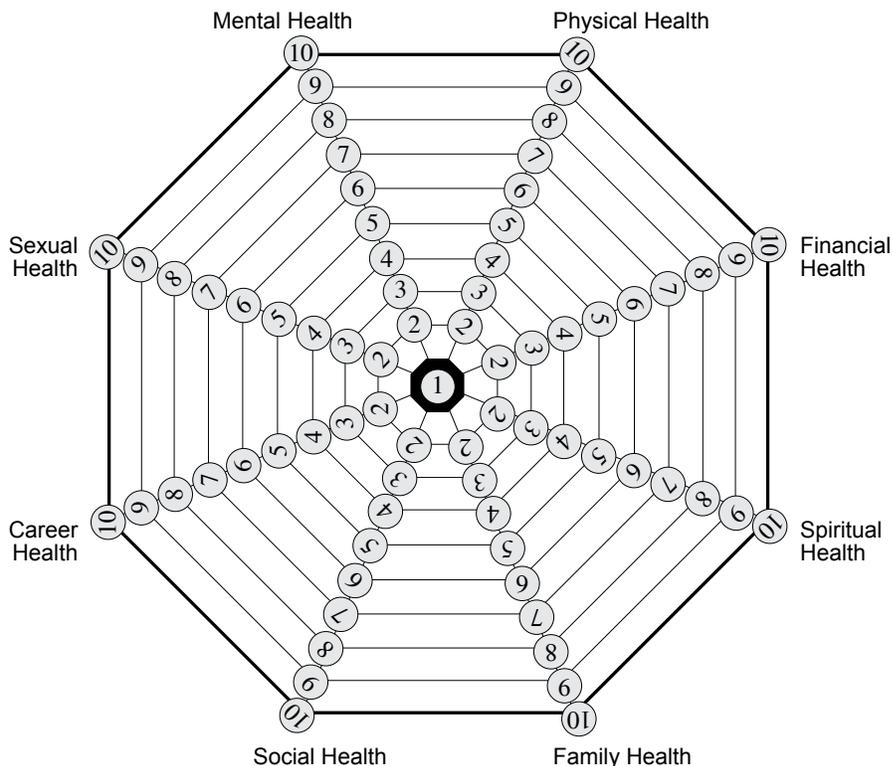
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



### Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

**Pain intensity levels** (please indicate below which best describe)

No pain      Moderate pain      Severe pain      Terrible pain

**Sleeping**

No problem      Mildly disturbed      Greatly disturbed      Cannot sleep

**Work - Can do:**

Usual work      25% of work      50% of Work      No work

**Frequency of pain**

25% of time      50% of time      75% of time      100% of time

**Travel**

No problem on long trips      Moderate pain on trips      Severe pain

**Recreation - Can do:**

All activities      Some activities      No activities

**Walking**

Can walk any distance      Pain after 1/2 mile      Cannot walk

**Sitting**

No pain sitting      Some pain while sitting      Cannot sit

