Carlsbad Village Acupuncture

Symptom Survey

Please indicate all that apply:

Energy level - at what time of day is it:

- ☐ High _____
- ☐ Low _____

Stress - my current level is…

- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Severe

Sweating

- ☐ Rarely sweat
- ☐ Excess sweat
- ☐ Night sweats

Circulation - I usually…

- ☐ Feel hot
- ☐ Feel cold
- ☐ Bleed / bruise easily
- ☐ Have cold limbs

Skin

- ☐ Dry
- ☐ Itchy
- ☐ Moist / clammy
- ☐ Burning
- ☐ Changing moles or lumps (cysts / tumors)
- ☐ Boils
- ☐ Frequest skin rashes
- ☐ Acne
- ☐ Hair loss / thinning
- ☐ Dry scalp
- ☐ Puffy or wrinkled skin
- ☐ Hives
- ☐ Other _____

Sleep

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Usually restful
- ☐ Excess or vivid dreaming
- ☐ Average number of hours per night =_____

Head

- ☐ Dizziness
- ☐ Memory loss
- ☐ Loss of balance
- ☐ Light-headedness
- ☐ Headaches
- ☐ Other _____

Eyes

- ☐ Eye pain
- ☐ Dry eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Lossof vision

Ears

- ☐ Hearing loss
- ☐ Earaches
- ☐ Discharge / infections
- ☐ Ringing / buzzing
- ☐ Other _____

Nose

- ☐ Frequent nose bleeds
- ☐ Sinus trouble
- ☐ Seasonal allergies
- ☐ Frequent colds
- ☐ Other _____

Throat / Mouth

- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Jaw problems
- ☐ Tooth / gum problems
- ☐ Swollen tongue
- ☐ Other _____

Chest

- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Mucus rattles when breathing
- ☐ Trouble breathing at night
- ☐ Pain / pressure in chest
- ☐ Palpitations
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Coughing phlegm
- ☐ Other _____

Bowels

# of bowel movements per day_____

- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Black stools
- ☐ Mucus in stools
- ☐ Hemorrhoids / anal fissures
- ☐ Lower bowel gas
- ☐ Stools have foul odor
- ☐ Other _____

Urine

- ☐ Frequent urination: __at night __during the day
- ☐ Strong smelling
- ☐ Difficulty urinating
- ☐ Pain or burning with urination
- ☐ Blood in urine
- ☐ Frequent infections
- ☐ Incontinence
- ☐ Sensitive to light

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Symptom Survey

Please indicate all that apply:

Musculoskeletal - pain in…

- ☐ Neck
- ☐ Shoulder
- ☐ Between shoulders
- ☐ Arms / hands - left, right or both
- ☐ Hip
- ☐ Knee - left, right or both
- ☐ Fingers
- ☐ Big toe
- ☐ Upper back
- ☐ Mid back
- ☐ Lower back
- ☐ Bones sore / painful
- ☐ Loss of grip
- ☐ Swollen knees / elbows
- ☐ Leg cramps at night
- ☐ Weakness in legs
- ☐ Weak ankles
- ☐ Stiff all over
- ☐ Tingling / burning in feet
- ☐ Muscle spasms / cramps
- ☐ Loss of feeling in hands/ feet
- ☐ Painful joints
- ☐ Bursitis
- ☐ Other _____

Neurological / Emotional

- ☐ Nervousness
- ☐ Depression
- ☐ Easily angered
- ☐ Easily irritated
- ☐ Frequent crying
- ☐ Worry / anxiety
- ☐ Mood swings
- ☐ Memory confusion
- ☐ Poor concentration
- ☐ Suicidal thoughts / tendencies
- ☐ Tremors
- ☐ Numbness / tingling in limbs
- ☐ Poor coordination
- ☐ Muscle weakness
- ☐ Feel weak and shaky
- ☐ Seizures
- ☐ Neuralgia (nerve pain)
- ☐ Shingles
- ☐ Other _____

Appetite

How many meals a day? _____

Specific food cravings _____

_____

- ☐ Excessive appetite
- ☐ Poor appretite
- ☐ Keeps changing
- ☐ Feel tired or weak if a meal is missed

Thirst

How much water do you drink daily? _____

- ☐ Excessive thirst
- ☐ Never thirsty
- ☐ Other _____

Digestion

- ☐ Stomach gas
- ☐ Lower bowel gas
- ☐ Heartburn / indigestion
- ☐ Burning / belching / acid reflux
- ☐ Stomach pain / cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Bad breath
- ☐ Sores in mouth
- ☐ Weight gain
- ☐ Weight loss
- ☐ Bitter / sour taste in mouth
- ☐ Abdominal bloating
- ☐ Other _____

Women only:

Are you or do you think you are pregnant? Y / N

If using birth control, what kind? _____

Date of last menstrual period _____

Average length of cycle _____

Date of last PAP smear _____

- ☐ Menstrual pain: before, during, or after period
- ☐ Cramping
- ☐ Irregular cycle / missed periods
- ☐ Heavy bleeding
- ☐ Light / scanty bleeding
- ☐ Clotting
- ☐ Painful breasts
- ☐ Hot flashes
- ☐ Decreased / increased libido
- ☐ Vaginal discharge
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Pelvic inflammatory disease
- ☐ Miscarriages
- ☐ Other _____

Men only:

Date of last prostate exam _____

- ☐ Prostate pain / swelling
- ☐ Decreased / increased libido
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Testicular pain / swelling
- ☐ Penile discharge
- ☐ Groin pain
- ☐ Urinary abnormalities / changes