



Significant trauma (auto accidents, falls, etc.)

Allergies (drugs, chemicals, foods)

Medications taken in the past two months (vitamins, drugs, herbs, etc.)

Have you ever been on a restricted diet? If yes, what kind?

Do you smoke? If yes, how much?

Please describe any use of drugs for non-medical purposes.

Indicate any painful or distressed areas:

**Please specify if you have had (in the past three months):**

**General**

Poor sleeping	Night sweats	Fevers	Chills
Cravings	Sweat easily	Weight loss	Change in appetite
Bleed or bruise easily	Strong thirst (hot or cold drinks)		Weight gain
Peculiar tastes or smells	Fatigue		
Sudden energy drop (what time of a day?)			

**Skin & Hair**

Rashes	Ulceration	Hives	Fevers
Itching	Eczema	Pimples	Dandruff
Loss of hair	Recent moles	Changes in hair or skin texture	
Any other hair or skin problems			

**Head, eyes, ears, nose, and throat:**

Dizziness	Concussions	Migraines	Glasses
Eye strain	Eye pain	Poor vision	Night blindness
Color blindness	Cataracts	Blurry vision	Earaches
Ringling in ears	Poor hearing	Spots in front of eyes	

Sinus problems  
Grinding teeth  
Teeth problems

Nose bleeds  
Facial pain  
Jaw clicks

Recurrent sore throats  
Sores on lips or tongue  
Headaches (where, when?)

### **Cardiovascular:**

High blood pressure  
Irregular heartbeat  
Cold hands and feet  
Blood clots  
Any other heart and blood vessel problems

Low blood pressure  
Swelling of hands  
Phlebitis  
Difficulty in breathing

Chest pain  
Fainting  
Swelling of feet

### **Respiratory:**

Cough  
Bronchitis  
Difficulty in breathing when take deep breath  
Broncheectosis

Coughing blood  
Pneumonia  
Loss of sense of smell and taste

Asthma  
Pain with a deep breath  
Production of phlegm; what color  
Sneezing and sininitis

### **Gastrointestine**

Nausea  
Constipation  
Black stool  
Bad breath  
Abdominal pain or cramps  
Any other problems with your stomach or intestines

Vomiting  
Gas  
Blood in stools  
Rectal pain  
Chronic laxative use

Diarrhea  
Belching  
Indigestion  
Hemorrhoids  
Poor appetites

### **Genito-Urinary**

Pain upon urination  
Blood in urine  
Kidney stones  
Sores on genitals  
Any particular color of your urine  
Any other problems with your genital or urinary system

How many times per day do you urinate:  
Urgency to urinate  
Decrease in urine flow  
Do you wake up to urinate? How often

Unable to hold urine

Impotence      Impotence

### **Musculoskeletal**

Neck pain  
Muscle weakness

Muscle pain:  
Foot/ankle pains

Knee pain  
Hand/wrist pains

Back pain  
Shoulder pain

Hip pain                      Any other joint or bone problems

### **Neuropsychological**

Seizure	Lack of coordination	Loss of balance
Areas of numbness	Depression	Poor memory
Concussion	Easily susceptible to stress	Anxiety
Bad temper	Tremors	

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

### **Please answer the following questions about Covid-19:**

#### **Please answer the following questions about Covid-19:**

1. Have you traveled outside of Florida within the last 14 days in the Airplane?

Yes                      No

If yes, where did you travel to?

If yes, is your Covid-19 test negative?

2. Have you or anyone in your home been hospitalized within the last 14 days?

Yes                      No

If yes, what for?

3. Have you or anyone in your home visited an urgent care facility within the last 14 days?

Yes                      No

If yes, what for?

4. Have you been in contact with anyone who has tested positive for Covid-19 or anyone that has any symptoms of the Covid-19/coronavirus within the last 14 days?

Yes                      No

5. Do you have coughing, difficulty breathing, loss of taste and smell sensation, headache, fatigue, body aches and high fever?

Yes                      No

If you do have the symptoms, please contact your physician for testing and treatment before coming in for acupuncture treatment.

**All patients are required to wear a mask that covers your nose and mouth when you come into the office and during acupuncture treatments.**

Thank you for protecting yourself and other patients

I testify that I will be treated by Li Zheng and Changhong Zhou, PhD, Licensed Acupuncturist and Herbalist, Boston Chinese Acupuncture Clinic for my medical condition under my own choice.

I understand the risks of the Covid-19 virus and I am using precautionary measures to avoid contracting it. I agree that Boston Chinese Acupuncture Clinic is in compliance with the precautionary measures needed to protect me during my acupuncture treatment.

**Signature:**

**Date:**