JAKE PAUL FRATKIN, OMD, L.Ac.

Doctor of Oriental Medicine, Licensed Acupuncturist

7764 Jade Ct. *(303) 554-0722*
Boulder, CO • 80303 *FAX (303) 554-0299*
www.drjakefratkin.com *e-mail:info@drjakefratkin.com*

Please Do Not Wear Perfume or Cologne to the Clinic

Today's Date:

NAME:

AGE: **DATE OF BIRTH:** **If child, parents' names:**

ADDRESS (Street, City, State, Zip):

Phone: (H) **(W)** **(CELL)**

Email:

RELATIONSHIP STATUS:

___ Single and living alone
___ Single and living with partner
___ Married. Spouse's name:

___ Children? Names and ages:

OCCUPATION:

REFERRED BY:

PRIMARY COMPLAINT:
Please include, briefly, location of complaint, time of onset, cause (if known), factors that aggravate symptoms, and any other pertinent information.

SECONDARY COMPLAINTS:

Please list all medications that you are currently taking. Include both prescription drugs as well as natural medicines (eg, herbs, homeopathics, vitamin supplements, etc.):

Are you currently being treated by other health care providers?

√	Type	Name of practitioner, city:
____	Medical doctor	
____	Chiropractor	
____	Naturopath	
____	Oriental Medicine	
____	Other	

What is your blood type?

How would you rate your current level of health?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Please check (√) the following if they presently apply to you. (Please **do not** write yes or no.) If you are suffering from a cold or flu, describe your condition prior to the onset of the cold.

ENERGY LEVELS

___ Are you fatigued, or do you fatigue easily?
___ Do you need to take naps?
___ Do you generally feel cold?
___ Do you have cold feet?
___ Do you have cold hands?

___ Do you ever have low grade fever?
___ Do your hands and cheeks warm up easily?
___ Do your feet get warm at nighttime, in bed?
___ Do you ever wake up sweating during the night?
___ (Men) - Do you have ejaculations during your sleep?

APPETITE AND TASTE

___ Has your appetite altered recently?
___ Do you have a poor appetite?
___ Do you have poor digestion?
___ Do you have epigastric (stomach) distention?
___ Do you have abdominal (large intestine) distention?
___ Are you experiencing belching?
___ Are you passing gas?

Do you have any of the following at least 3 times per week (Check √)

___Beef or pig meat	___Candy	___Pretzels
___Eggs	___Chocolate	___Chips
___Milk	___Bread	___Fruit juice
___Soy milk	___Pasta	___Soda
___Yogurt	___Pizza	___Wine
___Ice cream	___Potatoes	___Beer
___Cookies	___Crackers	___Hard alcohol

List any suspected or known food allergies:

THIRST AND DRYNESS

___ Do you have dry eyes?
___ Do you have dry nose or lips?
___ Do you have dry skin?
___ Do you have dry hair?
How many glasses of water or fluids do you drink daily? ____

STOOLS AND URINE

Are your stools:
___ Normal? (Daily with same shape and size)
___ Unusually hard?
___ Unusually loose?
___ Erratic in form (sometimes hard, sometimes loose)?

___ Do you have bowel movements less than 5 times per week (constipation)?
___ Is there any blood or pus in your stool?
___ Do you have hemorrhoids?

Is your urine:
___ Unusually scanty and dark?
___ Unusually profuse and clear?

___ Do you wake more than once at night to urinate?
___ Do you experience any dribbling of urine?
___ Do you have an urgency to urinate?
___ Do you experience burning with urination?

SLEEP

___ Do you suffer from insomnia?
___ If yes, do you fall asleep but wake up later?
___ Do you take medication for sleeping? How often?
___ Do you have restless sleep?
___ Do you have uncomfortable dreams?
___ What time to you fall asleep? ___ What time do you get up? ___ Total hours

EMOTIONS

Do you experience excessive: ___ Anger ___ Worry ___ Depression
___ Fear ___ Sadness ___ Anxiety
___ Do you experience mood swings?
___ Are they related to eating and not eating?
___ Do you take mood-regulating prescription medications?

STRUCTURE

___ Do you suffer from chronic or occasional backache or neck ache?
___ Do you suffer from chronic or occasional joint pain?
___ Do any muscles ache or cramp?

ACCIDENTS

Please list all major accidents, including fractures, deep cuts, serious sprains, etc. Please indicate all head injuries. Include dates or age:

SURGERIES

Describe reason, age, and any consequential outcome.

Have you ever had a blood transfusion? What year?

EXERCISE

What do you do for exercise? How often?

DISEASE HISTORY

Do your parents have any unusual health problems?
If they died, state cause of death and age at death.

FATHER: **MOTHER:**

During your mother's pregnancy with you, did she:

___ Drink alcohol
___ Smoke cigarettes
___ Take medications
___ Suffer serious illness
___ Suffer emotionally or physically

Please check if you have or have had any of the following:

Now	Past		Now	Past	
____	____	Anemia	____	____	Head injury
____	____	Arthritis	____	____	Headaches
____	____	Asthma	____	____	Heart murmur
____	____	Bruising	____	____	Heart palpitations
____	____	Cancer	____	____	Hepatitis: Type __
____	____	Candida	____	____	Herpes
____	____	Cholesterol, high	____	____	Hypertension
____	____	Chronic fatigue	____	____	Hypotension
____	____	Constipation	____	____	Kidney stones
____	____	Depression	____	____	Low sex drive
____	____	Diabetes	____	____	Mental illness
____	____	Diarrhea	____	____	Mononucleosis
____	____	Digestive problems	____	____	Nose bleeds
____	____	Dizziness, vertigo	____	____	Numbness, Neuropathy
____	____	Edema	____	____	Prostate problems
____	____	Epilepsy	____	____	Sciatic pain
____	____	Food allergies	____	____	Skin problems
____	____	Frequent colds	____	____	TMJ
____	____	Frequent gas	____	____	Ulcers
____	____	Gallstones	____	____	Venereal disease
____	____	Hayfever allergies	____	____	Parasites (type and date):

Any other serious illness, injury or complaint? If so, name:

<u>DRUG HISTORY.</u> Please indicate current or previous use of the following:

Now	Past		Years usage
____	____	Anti-depressants, mood modifiers	_____
____	____	Antibiotics	_____
____	____	Antacids (Prilosec, Tagamet, etc.)	_____
____	____	Birth control pills	_____
____	____	Hormone replacement therapy	_____
____	____	Pain medication (Prescription)	_____
____	____	Steroids (Prednisone etc.)	_____
____	____	Tagamet or other antacids	_____
____	____	Thyroid medication	_____
____	____	Alcohol (in excess)	_____
____	____	Cigarettes	_____
____	____	Amphetamines (incl. methamphetamine)	_____
____	____	Cocaine	_____
____	____	Heroin	_____
____	____	Marijuana	_____

WOMEN ONLY

Do you have a history of:

___ Amenorrhea (long time spans without a period)
___ Breast implants
___ Chronic vaginal or yeast infections
___ DES baby
___ Endometriosis
___ Hysterectomy. What year? ___
___ Irregular periods
___ Menstrual cramps
___ Miscarriage
___ Ovarian cyst
___ Pelvic Inflammatory Disease (PID)
___ Uterine fibroids

Birth control method (past or present); number of years usage:

Menstrual history.

___ Are you presently pregnant?
___ Are you presently suffering from menopausal disorder?
___ Have you completed menopause?

If you are still having your periods:

___ Is your period regular?
___ How many days between your periods?
___ How many days does your period last?
___ Are your periods painful?
___ Is your ovulation painful?
___ During menses, do you bleed excessively? ___ Too little?
___ Do you discharge clots?
___ Do you get headaches during menstruation or ovulation?
___ Do you suffer from premenstrual syndrome (PMS)? If yes, please indicate:
    ___ Breast distention
    ___ Irritability
    ___ Headache
    ___ Water retention

How many days before your period do the PMS symptoms begin? ____

Pregnancy history.

How many times have you been pregnant? ____

Did you have difficulty getting pregnant? ____

Did you have difficulty following childbirth? ____

Have you had any abortions? How many? ____

Have you had any miscarriages? How many? ____