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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 do 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	----	Suffer serious illness
----	Smoke cigarettes	----	Suffer emotionally or physically
----	Take medications		

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:

DRUG HISTORY. 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? _____