Satori
Acupuncture of Knoxville
Your body can stand almost anything;
it's your mind that you have to convince.

First Name: _____ Last Name: _____

Male/Female (circle one)

Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell Phone:_____

Email: _____ Occupation:_____

Date of Birth: _____ Age: _____Marital Status: _____

Emergency Contact: _____Phone: _____

Referred by: _____

Please describe the main reason for your visit today:

_____

_____

_____

Please indicate if you have any of the following (check one):

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

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List all major childhood and adult illnesses, surgeries, major accidents or injuries; please explain:

_____

_____

List all medications or supplements, including herbs and vitamins you are currently taking:

_____

_____

Do you have a regular exercise program? _____ Please describe.

_____

_____

Are you on a restricted diet? _____ What kind?_____

How much sugar/dessert do you eat per week?_____

How much dairy do you eat per week? _____

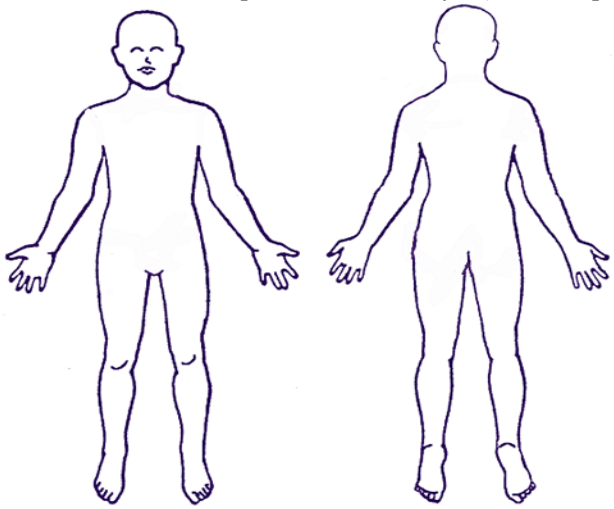
How many packs of cigarettes do you smoke per week?_____

How much caffeine (*coffee, tea, soda, energy drinks*) do you drink per week?_____

How much alcohol do you drink per week? _____

Do you do any drugs? How much per week? _____

Indicate the distressed areas. Please rate pain on a scale of 1 (minimal pain) to10 (worst pain).



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PATIENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

□ Cold hands/feet
□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily during daytime
□ Dizziness
□ See floating black spots

□ Palpitations
□ Sore on tongue
□ Restlessness
□ Anxiety
□ Chest pain
□ Insomnia

□ Cough
□ Sinus congestion
□ Dry mouth, throat, nose, or skin
□ Allergies seasonal or food
□ Chills and fever
□ Stiff neck/shoulders
□ Sore throat
□ Difficult breathing

□ Low appetite
□ Loose stools
□ Constipation
□ Abdominal bloating or gas after eating
□ Feeling tired after eating
□ Prolapsed organs (previously diagnosed)
□ Bruises easily
□ General feeling of heaviness in body
□ Mental heaviness or fogginess
□ Swollen hands/feet
□ Burning sensation after eating
□ Bad breath
□ Large appetite
□ Mouth, canker or cold sores
□ Bleeding, swollen or painful gums
□ Heartburn/belching
□ Stomach pain
□ Vomiting/nausea

□ Diarrhea alternating with constipation
□ Tight/suffocating feeling in chest
□ Bitter taste in mouth
□ Blood shoot eyes/dry eyes
□ Anger easily
□ Skin rashes
□ Headache
□ Numbness of hands and feet
□ Muscle spasms, twitching, cramping
□ Seizures/convulsions

□ Sore, cold or weak knees
□ Low back pain
□ Frequent urination
□ Get up more than once a night to urinate
□ Lack of bladder control
□ Memory problems
□ Hair loss
□ Ringing in ears (Tinnitus)

Urine is:

□ Normal color □ Clear
□ Dark yellow □ Reddish
□ Cloudy □ Scanty
□ Bad odor
□ Burning □ Painful
□ Difficult □ Urgent

Libido (sex drive) is:

□ Normal □ Low □ High

Women only:

1. Are you pregnant now?
□ Yes □ No

2. Number of children:_____

3. Number of pregnancies:_____

4. Is your menses cycle regular?
□ Yes □ No

a. Average number of days in flow:____
b. The flow is:
□ Normal □ Heavy □ Light

c. The color is:
□ red □ dark □ purple
□ light brown □ brown

d. Do you have the following menstruation related symptoms?
□ Blood clots
□ Cramps
□ Nausea
□ Breast distension
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods

e. Birth control:_____

Men Only:

a. Do you have any discomfort or issues with your reproductive organs?
□ Discharge
□ Pain or swelling of testicles
□ Ejaculatory problems
□ Impotence/erectile dysfunction

Signature _____

Date_____