

# Christina Bacigalupo, L.Ac

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Information provided on this form is confidential. Please print legibly.**

Name: \_\_\_\_\_  
Sex:  Male  Female      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Age: \_\_\_\_  
Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Email address: \_\_\_\_\_  
Telephone: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

Referred by: \_\_\_\_\_  
In order of importance, what do you want treated with acupuncture? How long have you had these conditions?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

The onset was  sudden  gradual

Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Physician \_\_\_\_\_  
What other health care practitioners are involved in your care? \_\_\_\_\_  
Medical diagnoses, if any? \_\_\_\_\_

Describe any significant injuries, surgeries, or major illnesses:

**Childhood:**

Age: \_\_\_\_\_

**Adolescence:**

Age: \_\_\_\_\_

**Adulthood:**

Age: \_\_\_\_\_

Age: \_\_\_\_\_

Age: \_\_\_\_\_

**Medicines/Supplements:**

Please check any of the following that you are now taking.

- Aspirin or Ibuprofen     Antidepressants     Antacids
- Oral Contraceptives     Diet Pills     Laxatives
- Sleeping Pills     Allergy Medication     Cold / Flu Medication
- Vitamins     Herbs     Other

Please list the names of any medication/herbs you are taking AND for what conditions.

# Christina Bacigalupo, L.Ac

## Past Medical History: Please check any or all that apply:

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> AIDS/HIV   | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hepatitis A/B/C           | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Herpes                    | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Lymes Disease             | <input type="checkbox"/> Thyroid Disorder    |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Multiple Sclerosis        | <input type="checkbox"/> Latex Allergy       |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Musculo-skeletal disorder | <input type="checkbox"/> Lymph nodes removal |
| <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Organ Transplant          | <input type="checkbox"/> Other _____         |

## Food and Drink:

How is your appetite? \_\_\_\_\_

Any food cravings? \_\_\_\_\_

List any food intolerances: \_\_\_\_\_

What did you eat yesterday:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

How often do you have: Meat: \_\_\_\_\_ Day/Week

Dairy: \_\_\_\_\_ Day/Week

What is your water intake? \_\_\_\_\_ 8 oz. glasses/day

Do you eat organic food? \_\_\_\_\_ % \_\_\_\_\_

Do you eat fast food? \_\_\_\_\_ % \_\_\_\_\_

## Gastrointestinal:

CHECK current symptoms. CIRCLE symptoms that have affected you in the past:

- |  |   |
|--|---|
| <input type="checkbox"/> Belching                                      | <input type="checkbox"/> Indigestion              |
| <input type="checkbox"/> Nausea  | <input type="checkbox"/> Severe stomach pain      |
| <input type="checkbox"/> Bowel Movements.<br>How often? _____ day/week | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Vomiting                                      | <input type="checkbox"/> Gas                      |
| <input type="checkbox"/> Incomplete bowel movements                    | <input type="checkbox"/> Bloating after meals     |
| <input type="checkbox"/> Vomiting blood                                | <input type="checkbox"/> Hemorrhoids              |
| <input type="checkbox"/> Painful bowel movements                       | <input type="checkbox"/> Poor appetite            |
| <input type="checkbox"/> Acid Regurgitation                            | <input type="checkbox"/> Undigested food in stool |
| <input type="checkbox"/> Irregular bowel movements                     | <input type="checkbox"/> Excessive hunger         |
| <input type="checkbox"/> Heartburn                                     | <input type="checkbox"/> Blood in stool           |
| <input type="checkbox"/> Constipation                                  | <input type="checkbox"/> Itchiness and/or burning |
| <input type="checkbox"/> Other _____                                   | <input type="checkbox"/> Other _____              |

## Exercise and Energy and Temperature:

How is your energy level (From 1 = lowest to 10 = highest)? \_\_\_\_\_

Do you fatigue easily? \_\_\_\_\_

What time of day is your energy: Highest? \_\_\_\_\_ Lowest? \_\_\_\_\_

What kind of exercise do you do? \_\_\_\_\_

How often do you exercise? \_\_\_\_\_ Days/Week

Do you have any unusual sweating?  Yes  No When? \_\_\_\_\_

In general, does your core feel hot or cold? \_\_\_\_\_ Cold Hands & Feet? \_\_\_\_\_

# Christina Bacigalupo, L.Ac

**Habits: Please check off any of the habits that apply to you now or in the past:**

<input type="checkbox"/> Caffeine	_____ # of coffees/day _____ # of teas/day _____ # of sodas/day	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Tobacco	_____ # of cigarettes/cigars per day _____ # of packs/day _____ age began smoking	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Alcohol	_____ # of glasses per day _____ age began drinking	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Marijuana	_____ # used per day/week _____ age began using	<input type="checkbox"/> Stopped _____ years/months/days ago
<input type="checkbox"/> Hard drugs (cocaine, crack, heroin, LSD, etc.)	_____ specify frequency	<input type="checkbox"/> Stopped _____ years/months/days ago

**Emotions and Sleep:**

How do you feel emotionally?

\_\_\_\_\_

CHECK any current symptoms. CIRCLE symptoms that have affected you in the past:

- |   |   |
|---|---|
| <input type="checkbox"/> Panic attacks            | <input type="checkbox"/> Fearfulness                      |
| <input type="checkbox"/> Poor memory              | <input type="checkbox"/> Frequent sighing                 |
| <input type="checkbox"/> Nervousness              | <input type="checkbox"/> Anger, irritability, frustration |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Obsessive thoughts               |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Suicidal thoughts                |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Other                            |

Married/Stable Relationship    Single    Divorced    Widowed

How do you feel about your relationship? \_\_\_\_\_

\_\_\_\_\_

Are you currently undergoing therapy? \_\_\_\_\_

Where do you hold stress? \_\_\_\_\_

How do you relax? \_\_\_\_\_

How do you feel about your work? \_\_\_\_\_

\_\_\_\_\_

How long do you normally sleep? \_\_\_\_\_ hours per night.

Do you feel refreshed in the morning? \_\_\_\_\_

I have difficulty with (please check any that currently apply):

- Falling asleep       Staying asleep  
 Disturbed sleep (dreams, light sleeper). Nightmares? \_\_\_\_\_  
 Waking up at about \_\_\_\_\_ am/pm and not being able to fall back asleep because \_\_\_\_\_

# Christina Bacigalupo, L.Ac

## Urinary & Genital:

I urinate approximately \_\_\_\_ times per day. I wake to urinate \_\_\_\_ times per night.  
Color:  pale yellow  dark yellow/brown/orange

CHECK any current symptoms. CIRCLE symptoms that have affected you in the past:

- |   |  |
|---|--|
| <input type="checkbox"/> Trouble starting stream            | <input type="checkbox"/> Blood in urine    |
| <input type="checkbox"/> Dribbling when sneezing / coughing | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Frequent urination                 | <input type="checkbox"/> Kidney stones     |
| <input type="checkbox"/> Frequent urinary tract infections  | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Incontinence                       |  |

How is your sexual energy? \_\_\_\_\_  
What kind of birth control do you use? \_\_\_\_\_

Do you have (check all that apply)

- Infertility  Pain during sexual intercourse  
 Other \_\_\_\_\_

## Women:

Are you *currently* pregnant?  Yes  No  
Are you *presently* trying to get pregnant?  Yes  No  
At what age did you start menstruating? \_\_\_\_\_  
Number of days between cycles? \_\_\_\_\_  
Duration of flow \_\_\_\_\_ Color \_\_\_\_\_ Clots? \_\_\_\_\_  
Quality (thick, thin) \_\_\_\_\_  
Age of Menopause \_\_\_\_\_  
How was your experience of menopause? \_\_\_\_\_  
(Peri)Menopausal Symptoms: \_\_\_\_\_

CHECK any current symptoms. CIRCLE symptoms that have affected you in the past:

- |   |  |
|---|--|
| <input type="checkbox"/> Irregular menses                       | <b>following</b> menses                              |
| <input type="checkbox"/> Vaginal itching/burning                | <input type="checkbox"/> Spotting between menses     |
| <input type="checkbox"/> Heavy flow                             | <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> Discomfort / pain <b>before</b> menses | <input type="checkbox"/> Breast lumps                |
| <input type="checkbox"/> Light flow                             | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Discomfort / pain <b>during</b> menses |  |
| <input type="checkbox"/> No flow                                |  |
| <input type="checkbox"/> Discomfort / pain immediately          |  |
- PMS Symptoms \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Number of deliveries? \_\_\_\_\_  
Abortions/Miscarriage(s)? \_\_\_\_\_

## Men:

CHECK any current symptoms. CIRCLE symptoms that have affected you in the past:

- |  |   |
|--|---|
| <input type="checkbox"/> Prostatitis                   | <input type="checkbox"/> Pain/ itching of genitalia |
| <input type="checkbox"/> Penis blood / mucus discharge | <input type="checkbox"/> Lump in testicles          |
| <input type="checkbox"/> Impotence                     | <input type="checkbox"/> Other _____                |

# Christina Bacigalupo, L.Ac

## Respiratory: Nose, Throat, Ears, Eyes and Head

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past:

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent colds (3 or more per yr)             | <input type="checkbox"/> Dry mouth                                |
| <input type="checkbox"/> Chronic cough                                 | <input type="checkbox"/> Bleeding gums                            |
| <input type="checkbox"/> Chronic runny nose                            | <input type="checkbox"/> Shortness of breath on exertion/ at rest |
| <input type="checkbox"/> Coughing blood                                | (please circle which)   |
| <input type="checkbox"/> Nose bleeds                                   | <input type="checkbox"/> Cold sores                               |
| <input type="checkbox"/> Changes in taste / smell                      | <input type="checkbox"/> Difficulty swallowing                    |
| <input type="checkbox"/> Coughing phlegm<br>Color _____ quantity _____ | <input type="checkbox"/> Frequent sore throat                     |
| (please circle which)  | <input type="checkbox"/> Other _____                              |
| <input type="checkbox"/> Pain inhaling                                 |   |

### Ears:

- Ear pain
- Ringing in ears — high / low pitch
- Clogged / popping ears
- Decreased hearing
- Other

### Eyes:

- Poor vision
- Pain red eyes
- See spots
- Dizziness
- Other

**Head:** Frequent Headaches / migraines. Please describe location and sensation

---

### Cardiovascular:

Blood pressure \_\_\_\_\_ / \_\_\_\_\_

Have you ever been diagnosed with heart trouble?  Yes  No

CHECK any current symptoms. CIRCLE any symptoms that have affected you in the past :

- |  |   |
|--|---|
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Varicose veins   |
| <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Irregular heartbeat |   |

### Skin and Hair:

CHECK any current symptoms. CIRCLE symptoms that have affected you in the past:

- |  |  |
|--|--|
| <input type="checkbox"/> Dry skin          | <input type="checkbox"/> Eczema                    |
| <input type="checkbox"/> Hives             | <input type="checkbox"/> Hair loss                 |
| <input type="checkbox"/> Bruise easily     | <input type="checkbox"/> Acne                      |
| <input type="checkbox"/> Skin rashes       | <input type="checkbox"/> Night sweating            |
| <input type="checkbox"/> Psoriasis         | <input type="checkbox"/> Changes in moles or lumps |
| <input type="checkbox"/> Premature graying | <input type="checkbox"/> Excess sweating           |
| <input type="checkbox"/> Itching           | <input type="checkbox"/> Other _____               |

# Christina Bacigalupo, L.Ac

## Muscles, Joints and Bones:

Do you have pain or tightness? Where? \_\_\_\_\_

What is the current level of pain, from 1-10? \_\_\_\_\_

The pain feels worse with: \_\_\_\_\_

The pain feels better with: \_\_\_\_\_

The pain is: (please check all that apply)

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp       | <input type="checkbox"/> Burning      |
| <input type="checkbox"/> Dull        | <input type="checkbox"/> Aching       |
| <input type="checkbox"/> Superficial | <input type="checkbox"/> Fixed        |
| <input type="checkbox"/> Deep        | <input type="checkbox"/> Moves around |
| <input type="checkbox"/> Tingling    | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Numbness    |                                       |

CHECK any current symptoms. CIRCLE symptoms that have affected you in the past

- |   |   |
|---|---|
| <input type="checkbox"/> Swollen joints         | <input type="checkbox"/> Muscle cramps / pain     |
| <input type="checkbox"/> Tendonitis             | <input type="checkbox"/> Repetitive strain injury |
| <input type="checkbox"/> Arthritis / joint pain | <input type="checkbox"/> Weak muscles             |
| <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Spinal curvature         |
| <input type="checkbox"/> Bone pain              | <input type="checkbox"/> Other                    |

**KEY: USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT**

- A = ACHE**
- B = BURNING**
- P = PINS & NEEDLES**
- S = STABBING**
- N = NUMBING**
- O = OTHER**

