KENNEALLY ACUPUNCTURE & HEALING RESOURCE CENTER

18635 Soledad Canyon Road #101
Canyon Country, CA 91351
www.keneallyacupuncture.com
661.252.4100

CASE HISTORY					
Today's Date:		**Referred By:**			
PERSONAL INFORMATION					
Name:					
Address:			**City:**		
State:		**Zip:**		**Home Phone #:**	
Work Phone #:				**Cell Phone #:**	
Social Security #:			**Sex:**	❑ M	❑ F
Email:					
Marital status:	❑ Single	❑ Married	❑ Divorced	❑ Widowed	
Birth Date:			**Age:**		
Number of Children:			**Ages:**		
Occupation:		**Employer:**			

MEDICAL INFORMATION		
Are you currently under the care of a MD, Chiropractor, Acupuncturist, Homeopath, Nutritionist, etc?	❑ Yes	❑ No
If so, please give name and time of treatment:		
Have your complaints been given a particular medical diagnosis?	❑ Yes	❑ No
If so, please name them:		
PRESENT COMPLAINT: Please list symptoms, when and how they started and anything that makes the symptom worse or better:		
Current Supplements, Vitamins, Glandular's, Herbs, Homeopathic Remedies, Supplements of Any Kind:		
Current Prescribed Drugs:		
Current Recreational Drugs (Include Frequency of Use):		

DAILY HABITS							
How much of the following do you consume daily:							
Cigarettes:			Water:				
Coffee/Tea:			Caffeine Beverages:				
Alcohol (What Form?)							
Dairy Products (Milk, Cheese, Yogurt, Etc)							
Meats/Fish/Poultry:							
Breads & Grains:							
Cooked Vegetables							
Raw Fruit & Vegetables:							
Specific Food Cravings:							
Typical Day's Menu:							
Breakfast:							
Lunch:							
Dinner:							
Snacks:							
Daily Exercise (Type and Duration)							
Which Of These Environments Effect You Adversely:							
❑ Cold	❑ Heat	❑ Damp	❑ Dry	❑ Windy	❑ Humidity	❑ Foggy	
Which Of These Environments Make You Feel Better							
❑ Cold	❑ Heat	❑ Damp	❑ Dry	❑ Windy	❑ Humidity	❑ Foggy	
Do You Have Intolerance to Hot Or Cold?					❑ Yes	❑ No	
Such As Food Or Drink? Areas of the Body That Are Hot or Cold?							
What Are Your Most Commonly Experienced Emotions?							
❑ Anger	❑ Worry	❑ Sadness	❑ Fear	❑ Grief	❑ Melancholy		
What Emotions Do You Have A Difficult Time Expressing?							
❑ Anger	❑ Worry	❑ Sadness	❑ Fear	❑ Grief	❑ Melancholy		
Please Describe:							
General Energy Level:							
Time of Day You Feel Best or Worst:							
History of Particular Emotional Episodes:							

PAST MEDICAL HISTORY			
Vaccination History (Include Any Reaction That You Remember):			
Childhood Illnesses – Any Surgery(s) or Accidents (Please List in Chronological Order)			
Ages 1 – 12:			
Ages 12 – 20:			
Age 20 – Present:			
History of Any Particular Emotional Difficulties or Shocks:			
WOMEN - Menstrual History			
Age When Periods Started:		**Last PAP**	
Past Difficulties With Periods (Pain, Flow, Regularity, Cramps, Etc.)			
Current Menstrual Problems (Pain, Bleeding, PMS, Vaginal Discharge):			
Birth Control History:			
Obstetric History:			
Menopause:			

MEN & WOMEN

Any History of Venereal Disease, Herpes, Etc:

MEN

Any History of Impotence, Premature Ejaculation, Fertility Difficulties, Discharge From Penis, Vasectomy, Etc:

List All Foods and Beverages Taken More Then Three Times A Week:

List Any Known Allergies:

List Specific Food Cravings:

FAMILY'S MEDICAL HISTORY:

Including any history of TB, cancer, skin diseases, high blood pressure, nervous disorders, diabetes, arthritis, heart disease, stroke, asthma, allergies, alcoholism, etc.

Father:	
Mother:	
Grandparents:	
Siblings:	

What Is The Most Important Health Change You Would Like To Occur?

Do You Have, Or Are You Currently:

Pregnant	❑ Yes	❑ No	Pace Maker	❑ Yes	❑ No
History of Hepatitis	❑ Yes	❑ No	Very High Blood Pressure	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No	Metal Allergy	❑ Yes	❑ No
Lowered White Blood Cell Count				❑ Yes	❑ No

PATIENT PROFILE

It is very important to know how long a patient has experienced his/her symptoms. Thus, it is essential to indicate time on the symptoms.

DATE:	
NAME:	

Indicate with one check any condition that you sometimes experiences. Use two checks for those which often occur, and three checks for symptoms that are a major concern.

WATER ELEMENT

❑ Hearing Loss ❑ Dizziness ❑ Lower Backache/Neck Pain ❑ Sinus congestion ❑ Edema ❑ Darkness Under the Eyes ❑ Emotional Instability	❑ Aversion to Cold ❑ Hair Thinning or Loss ❑ Premature Aging ❑ Frequent Urination ❑ Kidney Stones ❑ Perspire Very Easily ❑ Weakness of Legs/Knees	❑ Asthmatic Cough ❑ Rapid Weight Change ❑ Loose Teeth ❑ Reduced Sexual Energy ❑ Thyroid Problems ❑ Diabetes

WOOD ELEMENT

❑ Headaches ❑ Migraines ❑ Ringing in Ears ❑ Poor Eyesight ❑ Eye Infections ❑ Dry Eyes ❑ Eczema	❑ Shingles ❑ Herpes Simplex ❑ Warts ❑ Nervousness ❑ Convulsions, Spasms ❑ Irritability ❑ Constipation ❑ Hemorrhoids	❑ Hepatitis ❑ Ulcer ❑ Vomiting ❑ Gallstones ❑ Indecisive ❑ Fullness Below Ribs ❑ Shoulder/Neck Tension ❑ Insomnia 11 pm – 3 pm

FIRE ELEMENT

❑ Dry Scalp ❑ Skin Eruptions, Rashes ❑ Cysts, Tumors ❑ Ear Infections ❑ Sore Throat, Tonsillitis ❑ Lymphatic Swelling	❑ Hot Palms & Soles ❑ Heart Palpitations ❑ Aversion to Heat ❑ Bitter Taste in Mouth ❑ Gum Problems ❑ Nose Bleed ❑ Facial Redness	❑ Itching/Burning Skin ❑ Hot Hands/Feet ❑ Thirst ❑ Vivid Dreaming ❑ Dark Urine ❑ Night Sweats

EARTH ELEMENT		
❑ Indigestion ❑ Flatulence ❑ Food Allergy ❑ Stomach Ache/Ulcer ❑ Diarrhea	❑ Anemia ❑ Halitosis ❑ Sores in Mouth ❑ Heartburn ❑ Strong Appetite	❑ Weak Appetite ❑ Nausea ❑ Abdominal Bloating ❑ Low Body Weight
METAL ELEMENT		
❑ Bronchitis ❑ Asthma	❑ Shallow Breathing ❑ Cough	❑ Sinus Congestion ❑ Nasal Infections
OTHER ELEMENT		
❑ Fatigue ❑ Arthraigia	❑ Sciatica/Nerve Pain ❑ Cold Hands/Feet	❑ Tendonitis ❑ Bursitis
PAIN (Please Describe Below):		
OTHER COMMENTS:		
Thank you for providing this information. It is essential for your diagnosis and for your treatment. All of the above information will be held absolutely confidential.		
Date:		
Patient's Signature:		

PAIN ASSESMENT

DATE:		**NAME:**	
Chief Complaint 1:			
Chief Complaint 2:			

Is Your Present Problem Due to an Injury:

❑ On the Job	❑ Auto Accident	❑ Personal Injury	❑ Other

Did Your Pain Begin	❑ Gradually?	❑ Suddenly?
Do You Have Pain	❑ All the Time?	❑ Sometimes?

Is Your Pain Worse When You:

❑ Sit	❑ Bend	❑ Walk	❑ Lift	❑ Push	❑ Pull	❑ Other	

Which of the following areas do you have the most pain, discomfort, restriction or motion?

❑ Neck	❑ Shoulders	❑ Arms	❑ Hands	❑ Upper Back	❑ Mid back
❑ Low Back	❑ Pelvis	❑ Hips	❑ Legs	❑ Knees	❑ Feet	❑ Other

In An 8 Hour Day, Rate the Percentage of Your Pain When You:

Occasionally = 33%
Frequently = 34-66%
Continuously = 67-100%

Sit _____ %
Stand _____ %
Walk _____ %

What Percent of Your Time Are You:

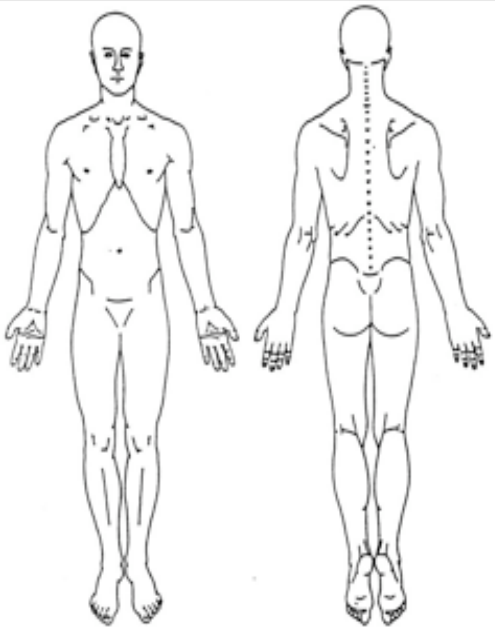
House Bound _____ %
Chair Bound _____ %
Bed Rest _____ %

Rate the severity of your pain by checking one box on the following scale:
1 = Least Pain
10 = Extreme Pain

10
9
8
7
6
5
4
3
2
1

Mark your areas of pain on figures below using these codes:

+++ Burning 0000 Stabbing
---- Sharp //// Constant



Does your pain interfere with your:	❑ Work?	❑ Sleep?	❑ Daily Routine?
Do You Feel Your Present Condition is:	❑ Temporary?	❑ Permanent?	❑ Don't Know?

List any additional comments you wish to make regarding your condition:

Patient Signature: _____