* highlight relevant for your condition option(s) if your answer is "Yes"
* leave blank if your answer is "No"
* fill in from left to right

Anamnesis (Medical History) F

1 . General Information

1.1

* **first name, last name:**
* personal number (if available, if not - give date of birth:):
* date of the 1st (planned) visit:

1.2

* **address:**
  * street, city, postal code (zip code):
* mob phone:
* e-mail:
* occupation:

1.3

* height:
* weight:

1.4

* **blood pressure, BP**:
  * normal
  * high/ low
    * provide your usual BP readings (if high or low):

1.5

* **occupational concerns, double click if your work (hobby) exposes you to the following:**
  * stress
  * exposure to wind/cold/heat/moisture/dryness conditions
  * negative environmental influence (which?):
  * computer (prolonged use)
  * prolonged sitting
  * heavy lifting
  * night shifts
  * other:

1.6

* **exercise**:
  * regular exercise
  * irregular exercise
  * extensive exercise
  * no exercise

1.7

* **diet:**
  * regular food intake
  * irregular food intake
  * low-fat
  * low-carb
  * high protein
  * vegetarian
  * vegan
  * high fiber
  * **other**:

1.8

* **pure water intake** (coffee/tea, juice, soup and soft drinks are not considered as pure water):
  * approx. glasses per day:

1.9

* **stimulants (legal intoxicants):**
  * **caffeine**:
    * coffee (cups/day):
    * black/green tea (cups/day):
    * soft drinks (cups/day):
    * carbonated drinks (how often):
    * energy drinks (how often):
  * **ephedrine:**
  * **nicotine**: past, present
  * **alcohol** (how often, how much):
  * **alcohol abuse**: past, present
  * **recreational drugs**: past, present

1.10

* have you had acupuncture before: y / n
* did you have a positive experience/outcome: y / n

1.11

* **how did you hear about us:**
  * internet
  * doctor
  * advertisement
  * friend
  * reference
  * other:

* highlight relevant for your condition option(s) if your answer is "Yes"
* leave blank if your answer is "No"
* fill in from left to right

2. CC (Chief Complaints)

2.1

*** chief complaint(s)** (in order of importance to you):

* mark (at the end of the description of your compliant) the intensity of the disorder, as: *–Sl–, slight; –M–, moderate; –S–, severe*

1.
2.
3.
4.
5.

2.2

*** your condition is:**

* *acute* (a newly occurred condition that can come and go, but has not been present for longer than three months)
* *chronic* (persists longer than for 3 months)
* *acute on chronic* (an acute exacerbation of a chronic condition)

2.3

*** have you received a *medical diagnosis* for your complaints/condition(s): yes/ no**

* if yes, then specify what *diagnosis:*

2.4

*** when/how did this condition occur (give dates if possible):**

*

2.5

*** character of pain (specify, and/or highlight more than one option, if applicable):**

* **location**:
  *
* **quality**:
  * smarting
  * burning
  * throbbing
  * dull
  * achy
  * lingering
  * well localized
  * radiating
  * wandering to different locations
  * + feeling of heaviness
  * + feeling of tingling
  * + feeling of cold
* **intensity**:
  * *Sl, M, S*
* **onset**:
  * slow, sudden
* **triggering conditions**:
  * overuse, still being, certain positions, other:
* **point in time**:
  * morning, afternoon, night, in no particular time
* **frequency**:
  * constant, intermittent

2.6

*** is your condition aggravated by:**

* motion/ rest
* hot/cold compress application
* applying pressure
* time of the day (specify what):
* time of the year (specify what):
* particular climate (specify what):
* particular circumstances
* emotions

*** is your condition alleviated by:**

* motion/ rest
* hot/cold compress application
* applying pressure

2.7

*** have you received medical treatment(s) for this condition, if yes, specify which:**

*

2.8

*** have you received an alternative medicine treatment(s) for this condition, if yes, specify which:**

* herbal therapy
* massage
* TENS (transcutaneous electrical nerve stimulation)
* hot/cold compress
* cupping
* liniments/ointments
* homeopathy
* chiropractic
* magnet therapy
* hot stone massage
* Ayurveda, other:

2.9

*** what treatments (if any) alleviated this condition the most?**

*

* highlight relevant for your condition option(s) if your answer is "Yes"
* leave blank if your answer is "No"
* fill in from left to right

3 HPI: *History of the Present Illness*

3.1

*** do you have a blood-borne disease:**

***** HIV, hepatitis B, hepatitis C, viral hemorrhagic fevers, other:

3.2

*** do you have:**

* metal implant (do not include dental implants), specify where:
* artificial cardiac pacemaker

3.3

*** do (did) you suffer any of the following medical conditions:**

* **autoimmune disease**:
  * Alopecia areata
  * Celiac / gluten intolerance
  * Crohn's disease
  * diabetes type 1
  * rheumatoid arthritis
  * Guillain-Barre's syndrome
  * Lupus erythematosus
  * myasthenia gravis
  * multiple sclerosis
  * vitiligo
  * primary ovarian insufficiency
  * **other**:

* anxiety
* anorexia / bulimia
* arthritis
* asthma
* back disorders
* bleeding tendency
* bursitis
* cancer (specify which type):
* **cardiovascular disorders** (include inborn heart defect, artificial pace maker, heart stent):
* depression
* diabetes
* epilepsy
* fainting
* food intolerance/hypersensitivity (ex.: lactose intolerance; not to be confused with food allergy)
* headaches
* hepatitis B, C
* insomnia
* kidney failure
* liver disorder
* migraine
* neurological disorder
* phobia (what to?):
* psychiatric disorders
* respiratory problems:
* seizures
* stroke
* tuberculosis
* weight problem
* **other:**

3.4

*** list surgeries / trauma (physical & emotional) / hospitalization you have had, and a year this occurred:**

*

3.5

*** allergies to** (highlight which, or specify)**:**

* animal dander
* food:
* medications:
* chemicals:
* seasonal changes
* environmental affects
* metal
* electricity
* odors (scents)
* **other**:

3.6

*** medications:** list all medications you use (by prescription and without),(remember inhalers, eye drops, nose sprays, topical creams)

* name:
* dose:
* purpose:
* how long:
* how often
* last intake:

3.7

*** supplements** (vitamins, minerals, metabolism enhancers, weight loss pills, mood enhancers, herbs, teas, other:)

* name:
* purpose:
* how long:
* dose:
* how often:
* last intake:

3.8

Family Medical History

*please indicate medical conditions (if any) that affected your blood ancestors as : "**p**" for parents, "**g p**" for grandparents

* AIDS / HIV:
* alcoholism:
* autoimmune disease:
* arthritis:
* anxiety:
* anorexia / bulimia:
* asthma:
* allergy:
* back disorders:
* cancer (what type):
* cardiovascular disorders:
* depression:
* diabetes:
* headaches/ migraine:
* hepatitis:
* high blood pressure:
* insomnia:
* kidney failure:
* liver disorder:
* thyroid disorder:
* tobacco:
* weight problem:
* tuberculosis:
* emotional problems:

* highlight relevant for your condition option(s) if your answer is **"Yes"** * leave blank if your answer is "**No**" * fill in from left to right

4. ROS: *Review of Systems* (systematic questioning about different organ systems)

4.1

*** body temperature (incl. subjective feeling of being warm and/or cold):**

* normal
* feeling of cold in the whole body
* cold hands/feet/both
* cold knees
* feeling of cold in the lower back
* feeling of heat in the whole body
* feeling of heat in the face
* hot palms and soles
* feeling of heat in the evening
* low-grade fever
* morning fever
* afternoon fever
* night fever
*" *five palm heat*" (low grade fever in the afternoon + hot palms and soles)
* alteration of feeling of cold/heat
* fixed fever / feeling hot 15-17.00

4.2

*** sweating:**

* **when**: day, night, night and day, particular point in time (specify which):
* **where**: hands, feet, just palms, just soles, arms, legs, whole body, upper body, chest, head, face
* **amount:** profusely, little

* **quality**:
  * sticky alike oil drops, cold, hot, yellowish
  *cold limbs after sweating ← kidneys fail to receive Qi ≈ kidney-yang xu

4.3

*** sleep:**

* normal
* somnolence at day time
* difficult to fall asleep
* difficult to wake up
* waking up at night time, clear mind, wide awake and active
* waking up at night time, feel tired and sleepy, but cannot fall asleep
* waking up early in the morning, cannot fall asleep
* waking up at night time + somatic symptoms: ex.: restless legs, itching, hunger, etc.)
* snoring
* vivid dreams
* nightmares

4.4

*** thirst:**

* normal
* excessive, desire to drink in big gulps (polydipsia)
* excessive, but no desire to drink or desire to drink in small sips
* only at night time
* preference to drink cold/ warm water/drinks
* + dry mouth, but preference only to rinse the mouth not to drink
* + dry throat
* + abundant and frequent urination

4.5

*** appetite:**

* normal
* poor
* excessive hunger
* prefer warm/cold food
* cannot feel the taste
*prefer particular foods/ tastes: *sweet, sour, bitter, salty, pungent/spicy*

4.6

*** digestion:**

* sluggish
* fullness sensation after meal
* tiredness after food intake
* bloating sensation
* belching
* reflux/heartburn
* nausea before/after food intake
* vomiting
* flatulence /gases
* pain (specify location):
* upper abdomen
* lower abdomen
* sides of the abdomen
*before /during/ after food intake

4.7

*** stool:**

* regular/irregular
* less than 3 times per week
* more than 3 times a day
* normal /hard/ dry/ loose
* dry first, then loose
* alternating loose/ hard
* thin, + long
* rounded (as goat's excrements)
* + mucus
* + yellow pus/discharge
* presence of undigested food
* + sharp/strong odor
* sensation of incomplete evacuation
* sensation of exhaustion after evacuation
*pain: before/ during /after evacuation
*blood: on evacuation, before evacuation, after evacuation
*colour:
  * black, dark, yellow, greenish

4.8

*** diarrhea:**

* occasional, chronic
* early morning
* watery
* + undigested food in stool
* + yellow puss
* + sharp/strong odor
*+ burning sensation in anus
* + abdominal swelling
* +belching, +gases
* slow, explosive
* **colour**: dark/ light yellow
* **pain**:
  *prior/ during /after evacuation

4.9

* **constipation:**
  * chronic / occasional
  * + dry stool, + thirst
  * normal stool, but difficult to evacuate, + fatigue following evacuation, + sweating following evacuation
  * dry stool, thus difficult to evacuate + fatigue following evacuation
  * normal stool, but absence of evacuation for several days
  * + cramping pain in the abdomen
  * rounded in shape, but not dry

4.10

* **anus:**
  * **hemorrhoids** * **prolapse** (sinking sensation) on evacuation * **itching in anus** * **fissures** (cracks)

4.11

* **urination:**
* **pain:**
  * smarting
  * prior to urination
  * during the urination
  * following the urination
  * in lower abdomen, sacrum
  * + difficulty on urination
* **frequency:**
  * frequent
  * frequent + urgent + painful
  * frequent + scarce
* **amount**
  * abundant (with normal water intake)
  * scarce (with normal water intake)
  * scarce + painful + frequent + dark yellow urine
* **colour:**
  * normal (clear, light yellow)
  * white (no yellow present)
  * dark yellow, dark red, reddish yellow
* **clarity:**
  * clear, cloudy
  * presence of blood, sand, white mucus
* **difficulty on urination**, + edema/ swelling in some parts of the body
* **dribbling after urination**
* **weak-stream urination**
* **incontinence** (involuntary urination, any leakage of urine ex on exertion, laugh, coughing, sneezing, exercise)
* **enuresis** (repeated inability to control urination)
* **nocturnal enuresis** (nighttime bedwetting), + teeth clenching
* **nocturia** (wake up at night one or more times for voiding)
* **anuria** (absence of urination)

4.12

* **headache /migraine:**
  * chronic, occasional
* **character of pain:**
  * dull
  * throbbing
  * smarting
  * pulsating
  * lingering
  * + feeling of heaviness in head
  * + feeling of emptiness
  * + occipital stiffness
  * + shoulder and neck stiffness
  * + dizziness
* **location**:
  * entire head
  * frontal (on the forehead)
  * occipital (adjacent to the neck)
  * vertex
  * behind the eyes
  * temples/sides/behind the ears (one side or both)
* **intensity**:
  * *SL, M, S*
* **frequency**:
  * constant, intermittent
* **point in time**:
  * morning, afternoon, night, in no particular time
* **onset**:
  * slow, sudden
* **triggering conditions**:
  * anger
  * stress
  * over activity (mental or physical)
  * still being
  * horizontal body position
  * after sexual activity
  * after meal
  * after sour food intake
  * before/after/during menstruation
  * damp weather
  * **other:**

4.13

* **vertigo (dizziness)**
  * **onset**: sudden / gradual
  * + feeling of heaviness, + nausea, + difficulty to concentrate especially in the morning
  * slight dizziness only with change in head position, + insomnia, + palpitations, + memory problems
  * persistent dizziness + feeling emptiness in the head + tinnitus + depression
  * triggering conditions (specify, what):

* highlight relevant for your condition option(s) if your answer is "**Yes**"
* leave blank if your answer is "**No**"
* fill in from left to right

5. Sensory Organ System Review

5.1

*** eyes:**

* **vision disorders** (specify which):
  * *hyperopia*, *myopia*, *glaucoma*, squinting(*strabismus*), *astigmatism*

other:

* blurry vision
* floaters in eyes
* double vision
* discharge: yellow, white
* sensitivity to light
* sclera (red, yellow, bluish)
* swelling (upper /lower eyelids)
* redness of eyelids
* swelling of eyelids
* itching
* tearing
* tearing only on wind
* dryness
* tics
* pain

5.2

*** ears:**

* pain
* recurrent inflammations
* **tinnitus:**
  * sudden onset, high pitch
  * gradual onset, constant, low pitch
  * \+ blockage in the ear
  * alike rumble of a large clock, worse/better in intervals, triggered typically by anger
  * \+ deafness + pain + swelling
  * worse by overwork and in the afternoon
  * \+ long-term deafness, sound as if cicada, worse at night
  * deafness worse on exertion or rising, sudden onset, + cold, emptiness feeling in the ear
* hearing problems
* itching
* earwax excess
* feeling of pressure behind the ear
* discharge
* **bleeding:**
  * sudden onset + pain
  * gradual onset, small amount, intermittent, no pain or swelling

5.3

*** nose:**

* congestion
* recurrent inflammations
* swelling
* cold nose
* dry nasal passages
* *anosmia* (inability to smell)
* *hyposmia* (decreased ability to smell)
* *hyperosmia* (an abnormally acute sense of smell)
* itching
* burning pain in nasal passages

* **discharge**:

* abandon, clear, dry
* thick, watery
* yellow, white
* \+ pain
* \+ redness, dryness around, nostrils
* \+ foul odour (can be felt on exhalation)

* **bleeding (epistaxis):**

* little blood, + fever
* little fresh red blood, + dry painful nose
* abundant fresh red blood
* abundant bright red or crimson red blood, often following after emotional distress
* pale red blood, slow bleeding, easily starts easily ends, recurring
* abundant, bright red blood, coming at irregular intervals, recurring

5.4

*** mouth:**

* dryness
* ulcers
* bitter taste
* bad taste
* foul breath
* excessive salivation
* burning sensation on the tongue
* bleeding gums
* gum atrophy
* periodontitis
* gum redness
* tooth grinding (bruxism)
* toothache
* caries

5.5

*** lips:**

* colour: bright red, pale, purple, bluish
* dryness
* ulcers
* cracks
* lip tremor
* lips swelling, itching

* highlight the relevant for your condition option(s) if your answer is "**Yes**"
* leave blank if your answer is "**No**"
* fill in from left to right

6.1 Andrology/ Sexuality

*** sexual dysfunctions:**

* lack of /decreased libido (sexual desire)
* impotence (or erectile dysfunction = inability to develop or maintain an erection)
* anorgasmia (delayed/inhibited ejaculation)
* premature ejaculation
* spermatorrhoea (seminal emissions)
* nocturnal emissions without dreams ← kidney-qi not firm ≈ kidney-yang xu
* nocturnal emissions with dreams ← yang is not rooted
* excessive sexual desire
* low sperm count
* cold, thin sperm

---6.2 *

prostate dysfunctions:

* prostatitis
* benign prostatic hyperplasia (enlargement of the prostate)

---6.3 *

infertility

---6.4 *

other:

* priapism (penis remains erect for hours in the absence of stimulation or after stimulation has ended)
* orchitis (inflammation of the testes)
* seminal vasculitis (spermatocystitis)
* spermatocele (cysts formation in the area of testes)

Do not fill in, filled by practitioner

Tongue 1.1

*** body:**
- * Shen
- * stomach Qi

*** coating:**
- * colour: white, yellow, grey, brown, black → location:
- * thin, thick
- * moist, dry, sticky
- * absence → location:
- * root

* **colour**:
- * normal, red, pale, purple, black
- * red sides, red tip
- * discolorations → location:

* **form:**
- * teeth marks
- * bowl form
- * raised sides
- * rolled
- * thin, swollen
- * long/short
- * slanting
- * protrusions(location):
- * depressions (location):
- * dots, patches
- ***stability**:
  - * torpid, rigid/hard, slack, trembling, moving
- * cracks → location:
- * ulcers/blisters

*** under tongue:**
- * luster: pale, yellow
- * yellow: middle / sides
- ***** protrusions
- * **veins** ← blood circulation:
  - * symmetry ← circulation← stasis xue
  - * branching ← stasis xue
  - * short, narrow, thick
  - * too dark ← stasis xue
  - * **other**:

Puls 1.2

*** general:**
* stomach Qi * Shen

*** 3 levels:**
* superficial ← Yang, skin + muscles → lungs + spleen , *nerves*
* middle ← Qi, sinews + blood vessels → liver + heart, *vascular*
* deep ← Yin, bones → kidneys, *organ tissues*

*** 3 positions:**

*** left:**
1. **cun:** heart/SI/ *shanzhong*
2. **guan:** liver/ GB
3. **chi:** kidneys / Bl / SI

*** right:**
1. lungs/ LI
2. spleen/ stomach
3. kidney/Bl/ uterus, pericardium/ TB/ LI

*** left:**
* blood; + Rear ← Qi of Kidney-Yin

*** right:**
* Qi ; + Rear ← Qi of Kidney-Yang

*** quality:**
- * speed (fast - slow):
- * level (shallow - deep):
- * strength (with without):
- * diameter (thick- thin):
- * tension(tense):
- * length (long - short):
- * root (with - without):
- * rhythm (intermittent: stops regularly/ irregularly):
- * form/other qualities:

* palpation of the body 1.3

* tense / lax, pain, cold / hot, wet / dry, sticky, ticklish, Sha

*** front**:
- * mu points:
- * means zones:
- * meridian points:
- * Ashi points:
- * extraordinary meridians:

*** back**:
- * shu points:
- * vertebrae :
- * organ zones:
- * ashi:

Diagnosis
*

Therapy

Improvitas AB
Acupuncture and TCM Clinic

Värmdövägen 207
131 41 Nacka,
Sweden
+ 4684669222