Name	Healing room Koufukuji Acupuncture Clinic Medical Check Form	Date: D M Y Patient No:

Birthdata: D M Y	M ／ F	Height cm	Weight kg
Address: 〒 ─ Age TEL ( )			

Profession	Surgical history?(What? Age)
Current medical complaint:	

Is or was the above treatment previously treated, examined or medicated? Yes ／ No

Sickness／Disease	Type/s of examination	Treatment	Medication/Dose

*Please circle of write your symptoms and complaints below. Be sure to check all sections.

Agility	head-neck-chest-hips-shoulder-back-abdomen-side abdomen-arms-legs-knees-heel Symptom (painful-numb-chronic pain-swelling-dropsy-stiffness-twitch-itch)
Head	*Temple pain *Base of skull(pain-heavy) *Head(pain-heavy) *Chronic headache *Face feels hot *Eye(tired-slow-pain-dry-teary-heavy) *Ear(ringing-declined-pain defective-discharge) *Feel faint-Vertigo-Nausea *Oral canker-Corners of the mouth spit
Tonsils	*Catch a cold easily *Get a fever easily *Continuous mild fever *Excess(cough -phlegm) *Throat pain *Allergy symptom(asthma-sneezing-runny nose-blocked nose-conjunctivitis-pollen allergy-drug allergy-food allergy-dermatitis-hives-others( )
Chest	*Blood pressure(high-low) *Regular sleeping(hrs) *Short temper *Chest pain irregular *Heart palpitation *Short breath *Perspiring(dry-regular -too much) *hands/feet(hot-cold)
Abdomen	*No appetite *Heavy stomache *Heartburn *Stomache ache(full-empty) *Gastroptosis *Bloated feeling(full-empty) *Indegestion *Diarrhea(chronic-irregular) *Urination(very often-irregular-seepage-reluctance-painful-partial discharge-cloudy-bloody) *Stool(chronic-irregular) *Hemmaroids(external-pain) *Urinate(times/day) *Pee in midnight(times)
Lifestyle	*Smoking(pieces/day) *Alcohol(drinks/day) *Exercise(days /week: none) *Current medicine/s?(name:)
Females only	*Menstruation(yellow-red-white) *Menstral(cycle random-painful) *Menstral blood volume(very heavy-heavy-regular-light) *Symptoms(headache-lower abdomen pain-backache-nothing) *Menapause( )age

medical history

Have you had surgery or major injury?　Please circle and note body location.

***childhood medical history**

(illness, injury, surgery:) (age:)

(illness, injury, surgery:) (age:)

***adolescence medical history**

(illness, injury, surgery:) (age:)

(illness, injury, surgery:) (age:)

(illness, injury, surgery:) (age:)

***adult medical history**

(illness, injury, surgery:) (age:)

(illness, injury, surgery:) (age:)

(illness, injury, surgery:) (age:)

(illness, injury, surgery:) (age:)

(illness, injury, surgery:) (age:)

***ancestral illness**

please circle or note your families condition

ex) diabates, heart disease, neurological, high blood pressure, blood disorder, genetic disorder ,etc

***current medication**

over the counter, prescribed, chinese herbal medicine, vitamins, minerals

I'm currentry taking:

( )

( ).

I occasionally take:

( )

( ).

I have previously taken:

( )

( ).

***Do you have any scars?**

Resulting from injury, accident, surgery.

Please draw a hashed line on the body illustration below, noting approximate location and size.