KAISER PERMANENTE®
Center for Complementary Medicine

HRN Label

Acupuncture Conditions Inventory

Chief complaints: (1) _____ **(2)** _____ **(3)** _____

Section 1- Muscular Skeletal Pain:

Please circle the event(s) that led to your present pain:

Accident _____ Cancer _____ Following an Operation _____ No obvious cause _____

How long have you had this pain?

3 months or less | 3-6 months | 6-12 months | 12-24 months | More than 24 months

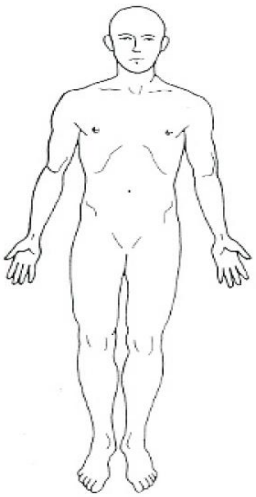
How often does this pain occur?

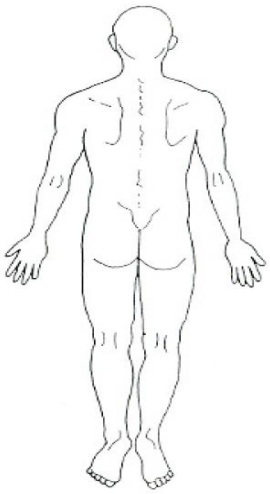
Continuously | Several times a day | Once or twice a day | Several days a week | Less than 4 times a month

How has the intensity of the pain changed throughout the time you have had it?

Increased | Decreased | Stayed the same

Location of pain: (On the diagram, check the areas where you feel pain)





Quality of Pain

From the list below of words that describe pain, check the words that describe your pain:

Throbbing	Shooting
Stabbing	Sharp
Hot burning	Aching
Heavy	Cramping

Factors that affect your pain (In what manner do the following factors affect your pain?)

Heat: Better/Worse	Sitting: Better/Worse	Noise: Better/Worse	Cold: Better/Worse
Walking: Better/Worse	Coughing: Better/Worse	Fatigue: Better/Worse	Standing: Better/Worse
Lying Down: Better/Worse	Anxiety/emotions: Better/Worse	Particular Position: Better/Worse	
Climate Change: Better/Worse	Massage/Rubbing: Better/Worse		

Section 2- Other Conditions: (circle any conditions you currently experiencing or have had in the past)

General Symptoms

Poor sleep	Lack of strength	Fever	Muscle cramps
Heavy sleep	Bodily heaviness	Chills	Vertigo/dizziness
Dream disturbed sleep	Cold hands or feet	Night sweats	Bleed or bruise easily
Fatigue	Poor circulation	Sweat easily	Peculiar taste: _____

Cardiovascular

High Blood Pressure	Blood Clots	Tachycardia	Heart Palpitations	Deep Vein Thrombosis
Low Blood Pressure	Fainting	Pacemaker	Defibrillator	
Phlebitis	Chest Pain	Irregular Heartbeat	Difficulty Breathing	

Are you taking blood thinners?: Yes/No

Respiratory

Difficulty breathing when lying down	Cough: Wet or dry? Thick or thin?	Pneumonia	Tight chest
Asthma/Wheezing	Shortness of breath	Coughing blood	

Your Diet

Appetite: Poor/Excessive	Coffee	Soft Drinks	Recent weight: Loss/Gain
Thirst for water	Salty Foods	Sugar	Strongly like cold drinks
# glasses of water per day: ____			Strongly like hot drinks

Your Lifestyle

Alcohol Tobacco Stress Level (1=no stress, 10=high stress) _____ Regular exercise? Yes/No

Family Medical History

Allergies _____	Alcoholism	Heart Disease	Stroke
Arteriosclerosis	Cancer _____	High Blood Pressure	Seizures
Asthma	Diabetes		

Your Past Medical History

AIDS/HIV	Diabetes	Measles	Stroke
Alcoholism	Emphysema	Mumps	Surgery _____
Allergies _____	Epilepsy	Pleurisy	Thyroid Disorders
Appendicitis	Goiter	Pneumonia	Major Trauma _____
Arteriosclerosis	Gout	Polio	Tuberculosis
Asthma	Heart Disease	Rheumatic Fever	Typhoid Fever
Cancer _____	Hepatitis	Scarlet Fever	Ulcers
Chickenpox	Herpes	Seizures	Whooping Cough

Other: _____

Head, Eyes, Ears, Nose, Throat

Glasses/contacts	Night blindness	Sores on lips or tongue	Ringing in ears	TMJ
Eye strain	Glaucoma	Dry mouth	Poor hearing	Earaches
Eye pain	Cataracts	Excessive phlegm	Earaches	Headaches
Red eyes	Teeth problems	Recurrent sore throat	Headaches	Migraines
Itchy eyes	Grinding teeth	Swollen glands	Migraines	Concussions
Spots on eyes	Lumps in throat	Gum problems	Enlarged thyroids	Nose bleeds
Poor vision	Blurred vision	Facial pain		

Gastrointestinal

Nausea	Hiccup	Constipation	Laxative use	Itchy anus
Vomiting	Bloating	Black stool	Hemorrhoid	Anal fissures
Acid Regurgitation	Bad breath	Bloody stool	Intestinal pain/cramping	Rectal pain
Gas	Diarrhea	Mucous in stool	Bowel movements daily? Yes/No	

Skin and Hair

Rashes	Ulcerations	Psoriasis	Dandruff	Hair loss	Fungal Infection
Hives	Eczema	Acne	Itching	Change in hair/skin texture	

Neuropsychological

Numbness	Poor memory	Anxiety	Easily Stressed	Considered/attempted suicide
Tics	Depression	Irritability	Abuse Survivor	Seeing a therapist

Genito-urinary

Pain on urination	Blood in urine	Venereal disease	Increased libido	Impotence
Frequent urination	Unable to hold urine	Bedwetting	Decreased libido	Premature ejaculation
Urgent urination	Incomplete urination	Wake to urinate	Kidney stone	Nocturnal emission

Gynecology

Age menses began _____	PMS	Vaginal sore	Breast lumps _____
Length of cycle _____	Clots	Vaginal odor	# pregnancies _____ # live births _____
Duration of flow _____	Vaginal discharge color _____		Premature birth _____
Irregular periods	Date of last Pap _____		Age at menopause _____
Painful periods	Date last period began _____		