Patient Information

Today's Date _____

Name _____ SS# _____-____-_____ Birth date ___ / ___ / _____

Address _____ Marital Status _____ Age _____ Gender M / F

_____ Emergency Contact (name & phone #) _____

Home Phone _____ Cell Phone _____ Work Phone _____ Occupation _____

Reffered by _____ Have you had Acupuncture before? ____ yes ____ no

Chinese herbal medicine? ____ yes ____ no

Reason for visit today: _____

Is it getting worse? _____ Does it bother your: Sleep ____ Work ____ Other _____

What seemed to be the initial cause? _____

What seems to make it better? _____ worse? _____

Are you under the care of a physician now? yes / no If yes, reason: _____

Physician name & phone number: _____

Other concurrent therapies:_____

Family Medical History

___ Allergies (whom) _____
___ Arteriosclerosis _____
___ Asthma _____
___ Alcoholism _____
___ Cancer _____
___ Diabetes _____
___ Heart Disease _____
___ High Blood Pressure _____
___ Seizures _____
___ Stroke _____

Your Past Medical History

Please check any of the following conditions you currently have,or have had in the past. Please also check if you feel any of the following are significant part of your medical history.

___ AIDS / HIV	___ Asthma	___ Emphysema	___ Hepatitis	___ Multiple Sclerosis
___ Alcoholism	___ Birth Trauma	___ Epilepsy	___ Herpes	___ Mumps
___ Allergies	___ Cancer	___ Goiter	___ Pacemaker	___ High Blood Pressure
___Appenicitis	___ Chicken Pox	___ Gout	___ Pleurisy	___ Arteriosclerosis
___Diabetes	___ Measles	___ Pneumonia	___ Polio	___ Heart Disease
___ Tuberculosis	___ Ulcers	___ Rheumatic Fever		___ Thyroid Disorders
___ Scarlet Fever	___Seizures	___ Typhoid Fever	___ Major Trauma (auto accidents, falls, etc)	
___ Stroke		___ Venereal Disease		___ Whooping Cough

___ Surgeries (list): _____
_____
_____

Other or Additional Comments:_____
_____

Your Diet

Appetite: ___low ___moderate ___high
Consumption: ___Coffee ___Soft Drinks ___Artificial Sweetner ___Sugar ___Salty foods
Thirst for water: # of glasses per day:___
Average Daily Menu:

Breakfast: Lunch: Dinner: Snacks:

Medications and Suppliments

Current Medications taken in last 2 months:_____

_____

Vitamins/Supplements taken in last 2 months:_____

_____

Your Lifestyle

___Alcohol ___Marijuana ____Stress Regular Exercise: type_____ frequency_____

___Tobacco ___Drugs ____Occupational Hazards type_____ frequency_____

General Symptoms

___Poor appetite ___Poor sleep ___Bodily heaviness ___Chills ___Bleed/Bruise easy

___Heavy appetite ___Heavy sleep ___Cold hands/feet ___Night Sweats

___Strongly like cold drinks ___Dream/Disturbed Sleep ___Poor circulation ___Sweat easily

___Strongly like hot drinks ___Fatigue ___Shortness of breath ___Muscle cramps

___Recent weight loss/gain ___Lack of strength ___Fever ___Vertigo/Dizziness

___Peculiar taste (describe)_____

Head, Eyes, Ears, Nose, Throat

___ Glasses ___ Red eyes ___ Poor vision ___ Glaucoma ___ Grinding teeth

___ Eye strain ___ Itchy eyes ___ Blurred vision ___ Cataracts ___ TMJ

___Eye pain ___ Spots in eyes ___Night blindness ___ Teeth problems ___ Facial pain

___Gum problems ___Recurrent sore throat ___Poor hearing

___Sores on lips or tongue ___Swollen Glands ___Earaches

___Dry mouth ___Lumps in throat ___Headaches

___Excessive saliva ___Enlarged thyroid ___Migraines

___Color of phlegm: ___Nose bleeds ___Concussion

_____ ___Ringing in ears ___Other head or neck problems: _____

_____

Respiratory

___Difficulty breathing ___Asthma/wheezing ___Coughing blood

when laying down ___Cough, Wet or Dry_____ ___Pneumonia

___Shortness of breath Thick or Thin_____

___Tight Chest ___Color of phlegm_____

Cardiovascular

___High blood pressure ___Chest pain ___Phlebitis

___Blood Clots ___Difficulty breathing ___Irregular heartbeat

___Low blood pressure ___Tachycardia

___Fainting ___Heart palpitations

Gastrointestinal

___Nausea ___Diarrhea ___Itchy anus

___Vomiting ___Constipation ___Burning anus

___Acid regurgitation ___Laxative use ___Rectal pain

___Gas ___Black stools ___Hemorrhoids

___Hiccup ___Bloody stools ___Anal fissues

___Bloating ___Mucus in stools ___Bowel movements:

___Bad breath ___Intestinal pain or cramping Frequency_____Color_____

Texture_____Form_____

Musculoskeletal

___Neck/shoulder pain ___Low back pain ___Limited range of motion

___Muscle pain ___Joint pain ___Limited use (describe)_____

___Upper back pain ___Rib pain

___Other (describe)_____

Skin and Hair

___Rashes ___Psoriasis ___Hair loss
___Hives ___Acne ___Change in hair/skin texture
___Ulcerations ___Dandruff ___Fungal infections
___Eczema ___Itching ___Other hair or skin problems_____

Neuropsychological

___Seizures ___Depression ___Abuse survivor ___Other_____
___Numbness ___Anxiety ___Considered suicide _____
___Tics ___Irritability ___Attempted suicide
___Poor memory ___Easily stressed ___Seeing a therapist

Genito-urinary

___Pain on urination ___Incomplete urination ___Decreased libido
___Frequent urination ___Venereal disease ___Kidney stone(s)
___Urgent urination ___Bed wetting ___Impotence
___Blood in urine ___Wake to urinate ___Premature ejaculation
___Unable to hold urine ___Increased libido ___Nocturnal emission

Gynecology

Age menses began ___ ___Vaginal sores Date of last PAP_____
Length of cycle(day 1 to day 1)_____ ___Vaginal odor Date last period began_____
Duration of flow_____ ___Clots
___Irregular periods ___Breast lumps
___Painful periods # Pregnancies___
___PMS # Live Births___
___Vaginal discharge Premature Births___
color_____ Age at Menopause___

Other:

IF YOU NEED TO CANCEL YOUR APPOINTMENT, WE APPRECIATE 24 HOUR NOTICE IF POSSIBLE. WE RESERVE THE RIGHT TO CHARGE FOR APPOINTMENTS BROKEN WITHOUT 24 HOUR NOTICE.

Patient Signature **Date**