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PATIENT INFORMATION

Welcome! Please take a moment to provide us with some information about yourself and your health so that we may do our best to treat you.

NAME (LAST, FIRST MIDDLE)	DATE

AGE	DATE OF BIRTH	SEX: MALE FEMALE	MARITAL STATUS: SINGLE MARRIED/PARTNERED OTHER

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELLULAR PHONE	EMAIL ADDRESS

OCCUPATION	BUSINESS PHONE
EMPLOYED BY:	

EMPLOYERS ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER Only if needed for your insurance

SPOUSE'S NAME

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE(s)

FAMILY PHYSICIAN	REFERRED BY:
HAVE YOU RECEIVED ACUPUNCTURE BEFORE?	HOW DID YOU HEAR OF US i.e advertising, referral, insurance provider list, word-of-mouth)?

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MEDICAL HISTORY

NAME (LAST, FIRST MIDDLE)	DATE

What is/are the main problem(s) you would like us to help you with? _____

_____

_____

How did this condition develop? _____

_____

How long has this condition persisted? _____

Is there anything that makes it better? _____

_____

Is there anything that makes it worse? _____

_____

Have you ever received treatment for this/ these conditions? __Yes __No

If yes, when? _____ By whom? _____

What was the diagnosis? _____

What kinds of treatment? _____

_____

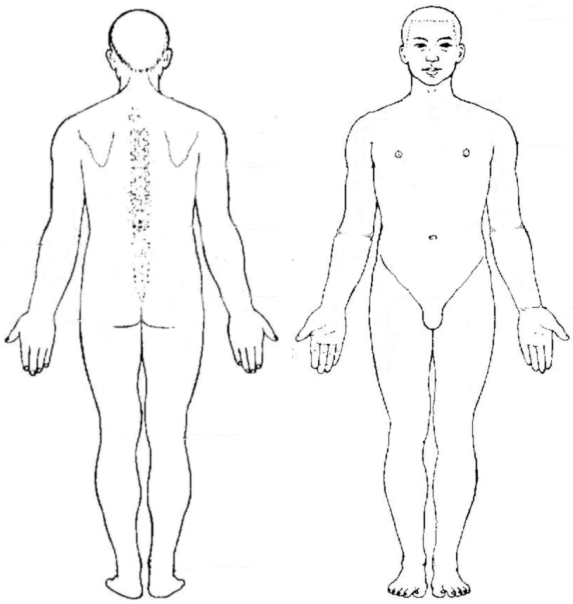
What were the results of the treatment? _____

_____

To what extent does this problem interfere with your daily activities (work, eating, sleep, sex)? _____

_____

Please indicate painful or distressed areas (if applicable):



On a scale of 0 to 10, with 10 the worst pain or distress you have ever experienced, what is your current experience? _____

What is the worst pain or distress you have experienced with this condition to date? _____

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MEDICAL HISTORY

NAME (LAST, FIRST MIDDLE)	DATE

Surgeries (type and date): _____

_____

Significant trauma (auto accidents, falls, etc.) **and scars**: _____

_____

Significant dental work (type and date): _____

Birth history (prolonged labor, forceps delivery, caesarian section, other): _____

_____

Significant illnesses/conditions (please check all that apply):

Anemia	Connective Tissue Disease	Hypertension	Ruptured Appendix
Arthritis	Diabetes	Kidney Stones	Seizures
Asthma	Gallstones	Malaria	Stroke
Autoimmune Disease	Heart Disease	Parasites	Thyroid Disease
Cancer	Hepatitis	Rheumatic Fever	Venereal Disease

Other: _____

Allergies (drugs, chemicals, foods, animals): _____

_____

List any medications, herbs, and nutritional supplements that you are currently taking including amount and frequency: _____

_____

_____

Diet Please give a general description of the food you eat during a typical day:

- Morning: _____
- Noon: _____
- Evening: _____
- Before bed: _____
- Between meals: _____

Please give the amount you consume per week:

Alcohol: _____ Coffee: _____ Tea: _____ Tobacco: _____

Have you ever been on a restricted diet? _____ If so, please describe: _____

_____

Exercise Do you exercise regularly? _____ Please describe: _____

_____

Biological Family Medical History

Anemia	Connective Tissue Disease	Hypertension	Seizures
Arthritis	Diabetes	Kidney Stones	Stroke
Asthma	Gallstones	Hepatitis	Thyroid Disease
Autoimmune Disease	Heart Disease	Migraines	
Cancer:		Allergies:	

Other: _____

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HEALTH HISTORY

NAME (LAST, FIRST MIDDLE)	DATE

Please check any symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Low energy
- ☐ Dizziness
- ☐ Allergies
- ☐ Fatigue
- ☐ Fevers
- ☐ Excess thirst
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweat spontaneously
- ☐ Night sweating
- ☐ Lack of sweating
- ☐ Weight loss
- ☐ Weight gain
- ☐ Aversion to heat
- ☐ Aversion to cold

Head & Neck
- ☐ Blurred vision
- ☐ Heaviness in the head
- ☐ Headache
- ☐ Phlegm in throat
- ☐ Cataract
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Eye pain/strain
- ☐ Corrected vision
- ☐ Nasal obstruction
- ☐ Nasal discharge
- ☐ Loss of sense of smell
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Recurrent sore throat
- ☐ Red/inflamed eye
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sores on lips
- ☐ Sores on tongue
- ☐ Taste change
- ☐ Teeth problems
- ☐ Vision – see halos

Respiratory
- ☐ Asthma
- ☐ Hay fever
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Recurrent bronchitis
- ☐ Phlegm production
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Hypochondriac pain
- ☐ Distention in chest or /pochondrium

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Bloody stools
- ☐ Black stools
- ☐ Difficulty swallowing
- ☐ Poor appetite
- ☐ Heartburn/reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Poor appetite
- ☐ Stomachache
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood

Diet/Lifestyle
- ☐ Vegetarian
- ☐ Healthy diet
- ☐ Eat much fried foods
- ☐ Eat much meat
- ☐ Smoke cigarettes
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Use drugs
- ☐ Eat a lot of sweets
- ☐ Take melatonin
- ☐ Take steroids
- ☐ Exercise regularly
- ☐ Exercise excessively

Weight
- ☐ Underweight
- ☐ Normal for height
- ☐ Overweight

Genitourinary
- ☐ Dilute urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Frequent urination
- ☐ Poor bladder control
- ☐ Urgency to urinate

Musculoskeletal
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Feet
- ☐ Hands
- ☐ Joints
- ☐ Legs
- ☐ Hips
- ☐ Neck
- ☐ Shoulders
- ☐ Pain all over
- ☐ Cold limbs
- ☐ Knee problems
- ☐ Low back pain
- ☐ All over weakness
- ☐ Lack of strength
- ☐ Broken bones

Skin
- ☐ Thick skin
- ☐ Thin skin
- ☐ Broken blood vessels
- ☐ Blood not clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Dark circles around eyes
- ☐ Bags under eyes
- ☐ Lumps in groin
- ☐ Lumps underarm
- ☐ Dry skin
- ☐ Acne
- ☐ Brittle nails
- ☐ Premature gray hair
- ☐ Dry, brittle hair
- ☐ Hair falling out

Neurologic
- ☐ Fainting
- ☐ Convulsions
- ☐ Handwriting change
- ☐ Paralysis
- ☐ Stroke
- ☐ Seizures
- ☐ Tremor
- ☐ Recent clumsiness
- ☐ Drowsiness
- ☐ Vertigo

Emotional
- ☐ Insomnia
- ☐ Irritability
- ☐ Often feel angry
- ☐ Troubling dreams
- ☐ Cry uncontrollably
- ☐ Feel sad a lot
- ☐ Forgetful
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Much fear
- ☐ Unrestrained joy
- ☐ Terrors
- ☐ Difficulty expressing emotions

Men Only
- ☐ Genital pain
- ☐ Impotence
- ☐ Genital sores
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Nocturnal emission
- ☐ Low sexual energy

Women Only
- ☐ Abnormal pap smear
- ☐ Bleed between periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ <25 day cycle
- ☐ >35 day cycle
- ☐ Endometriosis
- ☐ Painful periods
- ☐ Premenstrual tension
- ☐ Breast lumps
- ☐ Contraceptives
- ☐ Sores on genitalia
- ☐ Low sexual energy
- ☐ Vaginal discharges
- ☐ Menopausal
- ☐ Uterine prolapse
- ☐ Facial hair
- ☐ Loss of head hair
- ☐ May be pregnant