PATIENT INFORMATION

Name _____ Date_____

Home Address_____

City_____ State_____ Zip_____ Phone_____

E-mail Address_____ Cell Phone:_____

Business Address_____

City_____State_____ Zip_____ Phone_____

Occupation_____

Place of Birth_____

Date of Birth_____ Age_____ Height_____ Weight_____
Soc. Sec. #_# # # - # # - _____ (last 4 #)

Sex_____ Marital Status (Single, Married, Life Partner, Divorced, Widowed)

In Case of Emergency Notify_____

Family Physician _____ Contact # _____

Are you presently under a Dr's Care ? Yes No Who and for What _____

Any other therapies which you are involved in? _____

How did you hear of this office?_____
Have you ever tried Acupuncture or Oriental Medicine before? Yes No

Insurance Information –(only needed if billing Insurance for treatment)
Insurance Company _____Contact #_____

Policy, Plan or Group #_____ Soc. Sec. # _____

Co-Pay$_____ Referral Yes No Covered % _____

CHIEF COMPLAINT
What are the main health problems for which you are seeking treatment?

_____
Please rate the extent to which your current complaint affects your daily life
(1 = minor; 10 = major)_____
Please rate your commitment to resolving this problem (1 = minor; 10 = major)_____
What other forms of treatment have you sought?_____
_____

PAST MEDICAL HISTORY (check all which apply)

☐Allergies ☐Cancer ☐Diabetes
☐Hepatitis ☐High Blood Pressure ☐Heart Disease
☐Seizures ☐Rheumatic Fever ☐Surgeries
☐Venereal Disease ☐Thyroid Disease ☐Birth Trauma
☐Vaccinations ☐Childhood Illnesses ☐Accidents
☐Significant Trauma ☐Medications ☐Other (please specify)

FAMILY MEDICAL HISTORY (check all which apply and specify which blood relative)

☐Cancer ☐High Blood Pressure ☐Hepatitis
☐Rheumatic Fever ☐Infectious Disease ☐Diabetes
☐Heart Disease ☐Seizures ☐Emotional Disorder
☐Tuberculosis ☐Other (please specify)

LIFESTYLE (please indicate the use and frequency of the following)

☐Coffee ☐Black Tea ☐Tobacco
☐Alcohol ☐Caffeinated Beverages ☐Recreational Drug
☐Exercise (please specify type

MEDICATIONS
Please list any medications and/or supplements you are currently taking.

_____
_____
_____
_____
_____
_____
_____

GENERAL HEALTH (please check all that apply)

☐Poor Appetite ☐Disturbed Sleep ☐Insomnia
☐Fatigue ☐Poor Coordination ☐Weight Gain
☐Cold Hands and Feet ☐Night Sweats ☐Cold Abdomen
☐Tremors ☐Large Appetite ☐Localized Weakness
☐Strong Thirst ☐Weight Loss ☐Fevers

☐Poor Balance ☐Bruise/Bleed Easily ☐Sweat Easily
☐Cravings ☐Chills ☐Sudden Energy Drop
☐Soft/Brittle Nails ☐Catch Colds Easily ☐Other (please specify)

SKIN AND HAIR
☐Rashes ☐Itching ☐Dandruff
☐Ulcerations ☐Redness ☐Eczema
☐Psoriasis ☐Hair Loss ☐Hives
☐Pimples ☐Recent Moles ☐Other (please specify)

HEAD, EYES, EARS, NOSE, THROAT
☐Dizziness ☐Eye Pain ☐Blurred Vision
☐Floaters ☐Spots in Eyes ☐Night Blindness
☐Ringing in Ears ☐Poor Hearing ☐Earaches
☐Headaches ☐Migraines ☐Recurrent Sore Throats
☐Sores on Lips/Tongue ☐Dry Mouth/Throat ☐Bleeding Gums
☐Nosebleeds ☐Facial Pain ☐Jaw Clicking
☐Toothaches ☐Other (please specify)

CARDIOVASCULAR
☐Dizziness ☐Low Blood Pressure ☐High Blood Pressure
☐Irregular Heart Beat ☐Fainting ☐Cold Hands/Feet
☐Chest Pain ☐Swelling of Hands/Feet ☐Blood Clots
☐Difficulty Breathing ☐Palpitations ☐Other (please specify)

RESPIRATORY
☐Cough ☐Coughing Blood ☐Asthma
☐Bronchitis ☐Pneumonia ☐Coughing Phlegm
☐Pain with deep breath ☐Shortness of Breath ☐Nasal Congestion
☐Difficulty breathing when lying down ☐Other (please specify)

GASTROINTESTINAL
☐Nausea ☐Vomiting ☐Diarrhea
☐Constipation ☐Gas ☐Bloating
☐Belching ☐Abdominal Pain/Cramps ☐Indigestion
☐Heartburn/Reflux ☐Retention of Food in Stomach ☐Lack of Appetite
☐Excessive Appetite ☐Rectal Pain ☐Black Stools
☐Blood in Stool ☐Hemorrhoids ☐Bad Breath
☐Sensitive Abdomen ☐Chronic Laxative Use ☐Other (please specify)

GENITO-URINARY
☐Pain on Urination ☐Frequent Urination ☐Blood in Urine
☐Urgency to Urinate ☐Unable to Hold Urine ☐Kidney Stones
☐Decrease in Urine Flow ☐Impotence ☐Sores on Genitals
☐Waking at Night to Urinate ☐Other (please specify)

REPRODUCTIVE/GYNECOLOGICAL

Age of 1st Period _____ Age at menopause _____ # Pregnancies _____

Live Births_____ # Premature Births _____ # Miscarriages/Abortions ___

days between periods _____ # days of flow _____

Color of blood _____

☐Clots (Color _____) ☐Painful Menses ☐Irregular Menses

☐Premenstrual Symptoms ☐Strong Menstrual Odor ☐Vaginal Discharge

☐Vaginal Odor ☐Vaginal Dryness ☐Fibroids

☐Breast Lumps/Swellings ☐Endometriosis ☐Ovarian Cysts

☐Sexually Transmitted Disease ☐Urinary Tract Infection ☐Hot Flashes

☐Decreased Sex Drive ☐Positive Mammogram/Pap Smear

☐Other (please specify)

MUSCULO-SKELETAL

☐Neck Pain ☐Back Pain ☐Knee Pain

☐Muscle Pain ☐Foot/Ankle Pain ☐Shoulder Pain

☐Hip Pain ☐Hand/Wrist Pain ☐Sciatica

☐Muscle Weakness ☐Other Joint/Bone Problems (please specify)

NEURO-PSYCHOLOGICAL

☐Seizures ☐Dizziness ☐Loss of Balance

☐Areas of Numbness ☐Poor Memory ☐Lack of Coordination

☐Concussion ☐Depression ☐Anxiety

☐Bad Temper ☐Easily Stressed ☐Attempted Suicide

☐Treated for Emotional Problems ☐Other (please specify)