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. # _____

Sex _____ Marital Status (Single, Married, Life Partner, Divorced, Widowed) _____

In Case of Emergency Notify ~~PH#:~~ _____

How did you hear of this office? _____

Have you ever before tried acupuncture or Chinese herbal medicine? _____

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
- ☐ Fatigue
- ☐ Cold Hands and Feet
- ☐ Tremors
- ☐ Strong Thirst
- ☐ Poor Balance
- ☐ Cravings
- ☐ Soft/Brittle Nails
- ☐ Disturbed Sleep
- ☐ Poor Coordination
- ☐ Night Sweats
- ☐ Large Appetite
- ☐ Weight Loss
- ☐ Bruise/Bleed Easily
- ☐ Chills
- ☐ Catch Colds Easily
- ☐ Insomnia
- ☐ Weight Gain
- ☐ Cold Abdomen
- ☐ Localized Weakness
- ☐ Fevers
- ☐ Sweat Easily
- ☐ Sudden Energy Drop
- ☐ Other (please specify)

SKIN AND HAIR

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

HEAD, EYES, EARS, NOSE, THROAT

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

CARDIOVASCULAR

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

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Pain with deep breath
- ☐ Difficulty breathing when lying down
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Coughing Phlegm
- ☐ Nasal Congestion
- ☐ 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)