

Patient Information

Name: _____ Home Phone: _____ Work Phone: _____
Email: _____ Address: _____ City: _____
State: _____ Zip Code: _____ DOB: _____ Age: _____ Sex: _____ Ht: _____ Wt: _____
Social Security No.: _____ Marital Status: _____ No. of Children: _____
Occupation: _____ Employer: _____
Primary Physician: _____ Phone: _____
Emergency Contact Name: _____ Phone: _____ Relationship to You: _____

Insurance Info:

Insurance Company's Name and Address: _____
Policy No.: _____ Policy Holder's Name: _____ Phone: _____
Policy Holder's Address: _____ City: _____ State: _____ Zip Code: _____

Present History:

Main concern you would like me to help you with: _____

Other relevant complaints: _____

Is this a result of an injury or accident? _____ Yes _____ No When was the first time you were aware of this condition? (When and how did it start?) _____

Have you been given a diagnosis for this condition? If so, what? _____

What kinds of treatment(s) have you tried for this condition? _____

What makes it better? _____ What makes it worse? _____

Have you had acupuncture before? _____ If so, for what? _____

Medical History:

Please list current medicinals/ supplements: _____

Please list previous surgeries: _____

Have you ever been advised to have any surgery that was not done? _____

Have you ever been hospitalized? If so, explain: _____

Allergic to any medications? _____ Other known allergies? _____

Are you currently pregnant? _____ Yes _____ No Date of last menstrual cycle: _____

Have you ever had or do you currently have:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Epstein Barr |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> German Measles | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other: _____ | |

Family History: Has anyone in your immediate family ever had:

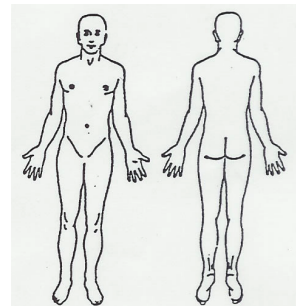
- | | | | | |
|--|---|--|------------------------------------|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Problem | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other: _____ | | |

If you are experiencing pain mark the area of your pain with the associated symbol.

- ++++ Sharp and Stabbing'
VVVV Achy
00000 Pins and Needles
///// Numbness

Patient's Signature: _____

Date: _____



Patient Information:

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Lifestyle

- Alcohol Tobacco Marijuana Drugs Stress Exercise
- Type _____ Frequency _____
- Type _____ Frequency _____

General Symptoms

- Poor appetite Big appetite Recent weight gain/ loss Fatigue after eating General fatigue
- Numbness Lack of strength Body feels heavy Strongly like cold drinks Strongly like hot drinks
- Poor sleep Heavy sleep Cold hands or feet Poor circulation Shortness of breath
- Fever Chills Night sweats Sweat easily Muscle cramps
- Vertigo/ dizziness Bleed, bruise easily Peculiar taste (describe) _____

Head, Eyes, Ears, Nose, Throat

- Headaches Migraines Poor vision Glasses Eye strain
- Eye pain Red Eyes Itchy eyes Blurred vision Night blindness
- Glaucoma Cataracts Teeth problems Grinding teeth TMJ
- Facial pain Gum problems Dry mouth Excessive saliva Sores on lips on tongue
- Sinus problems Recurrent sore throat Swollen glands Enlarged thyroid Nose bleeds
- Poor hearing Ear ringing Ear popping Earaches Concussions
- Loss of smell Change in taste
- Head or neck problems (explain) _____ Excessive phlegm (color) _____

Respiratory

- Shortness of breath Asthma/ wheezing Tight chest Pneumonia Coughing blood
- Difficulty breathing when lying down Cough recurrent? _____ wet/dry _____ thick/thin _____ phlegm/color _____

Cardiovascular

- High blood pressure Low blood pressure Chest pain Tachycardia Heart palpitations
- Blood clots Fainting Difficulty breathing Phlebitis Irregular heartbeat

Gastrointestinal

- Nausea Vomiting Acid regurgitation Gas Bad breath
- Hiccup Bloating Diarrhea Constipation Laxative use
- Black stools Bloody stools Itchy anus Rectal pain Hemorrhoid
- Anal fissures Mucous in stools Intestinal pain or cramping
- Bowel Movements: frequency _____ texture/form _____ color _____ odor _____

Musculoskeletal

- Neck/ shoulder pain Joint pain Low back pain Upper back pain Muscle pain
- Spinal curvature Walking problems Rib pain Muscular Atrophy
- Other (explain) _____

Skin and Hair

- Rashes Eczema Acne Hives Psoriasis
- Dandruff Ulcerations Itching Oozing lesions Hair loss
- Fungal infections Other hair or skin problems _____

Neuropsychological

- Seizures Depression History of abuse Anxiety Considered/attempted suicide
- Easily stressed Tics Irritability Poor memory Obsessive/compulsive behavior
- Seeing a therapist Other _____

Genito-urinary

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

Gynecology

- Age menses began _____ Date of last period _____ Length of cycle _____ Duration of flow _____ Color of blood _____
- Vaginal discharge (color) _____ Date of last PAP _____ Irregular periods Painful periods
- PMS Vaginal odor Vaginal sores Clots Breast Lumps
- # of pregnancies _____ # of miscarriages _____ # of abortions _____ # of premature births _____ Onset of menopause (age) _____

Other _____