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| **PATIENT INFORMATION** |

Name:       Date:

Home Address:

# City:       State: Post code:       Phone: ­­

E-mail:       Mobile Phone:

Occupation:       Business Address:

City:       State: Post code:       Phone:

Place of Birth       Date of Birth       Age       Height       Weight

Sex:  male;  female; Marital Status: Single, Married, Life Partner, Divorced, Widowed

In Case of Emergency Notify:       Phone:

How did you hear of this office?

Have you ever before tried acupuncture or Chinese herbal medicine?

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| **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?

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| **PAST MEDICAL HISTORY** (check all which apply) |

Allergies Cancer Diabetes

Hepatitis High Blood Pressure Heart Disease

Seizures Rheumatic Fever Surgeries

Sexually Transmitted Diseases Thyroid Disease Hospitalizations

Vaccinations Childhood Illnesses Accidents

Significant Trauma Medications

Other (please specify)

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

Cancer High Blood Pressure Hepatitis (A, B, C)

Rheumatic Fever Infectious Disease Diabetes (type 1 or 2)

Heart Disease Seizures Emotional Disorder

Tuberculosis Autoimmune Disease Endocrine Disorder

Other (please specify)

If deceased age of demise Father       Mother       Sibling/s

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

Coffee Caffeinated Beverages Tobacco

Black Tea Alcohol

Substance use (specify type)

Addictions (specify type)

If stopped use of any of above indicate how long and frequency of use:

Exercise (specify type)

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| **MEDICATIONS and SUPPLEMENTS** |

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

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| **GENERAL HEALTH** (please check all that apply) |

Fatigue or sudden energy drop Disturbed Sleep Cravings

Cold Hands and Feet Insomnia Weight Gain

Hot Hands and Feet Night Sweats  Large Appetite

Strong Thirst Fevers  Weight Loss

Tremors Sweat Easily  Poor Appetite

Poor Balance/Coordination  Chills  Cold Abdomen

Catch Colds Easily  Soft/Brittle Nails

Other (please specify)

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| **Previous Hospitalizations** |

Please specify (date and procedure)

**AIR**

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| **REVIEW OF SYSTEMS** |

**Please indicate any of the following repeated symptoms experienced in the last 5 years.**

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| **SKIN AND HAIR** |

Rashes Itching Clammy skin

Ulcerations Redness Skin dryness

Psoriasis or eczema Hives or rashes Hair Loss

Pimples or acne Recent Moles Dandruff

Jaundice Bruises Easily

Other (please specify)

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| **HEAD, EYES, EARS, NOSE, THROAT** |

Failing vision Deafness Allergies

Eye Pain Poor Hearing Sinusitis

Visual disturbances Ringing in Ears Post nasal drip

Floaters Ear aches Sores on Lips/Tongue

Blurred Vision Ear Discharge Dry Mouth/Throat

Night Blindness Headaches Toothaches

Eye Dryness Migraines Recurrent Sore Throats

Glaucoma Facial Pain Bleeding Gums

Eye inflammation Dizziness TMJ Jaw pain

Spots in Eyes Nosebleeds TMJ Jaw Clicking

Other (please specify)

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| **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)

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| **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)

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| **GASTROINTESTINAL** |

Nausea Vomiting Diarrhea

Bloating Gas Constipation

Belching Abdominal Pain/Cramps Sensitive Abdomen

Heartburn/Reflux Poor digestion Blood in Stool

Indigestion Bad Breath Black Stools

Lack of Appetite Hemorrhoids Rectal Pain

Excessive Appetite Chronic Laxative Use Incontinence

Other (please specify)

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| **UROGENITAL** |

Pain on Urination Frequent Urination Blood in Urine

Urgency to Urinate Unable to Hold Urine Kidney Stones

Decrease in Urine Flow Waking at Night to Urinate Sores on Genitals

Incontinence Other (please specify)

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| **GYNECOLOGICAL and FEMALE REPRODUCTIVE** |

Age of 1st Period:       Age of menopause:       # Pregnancies:

# Live Births:       # Premature Births:       # Miscarriages/Abortions:

# Days of cycle:       # Days of flow:       Flow stop then start:

Color and consistency of flow:

Clots Color       Size

Painful Menses Irregular Menses

PMS (Please specify)

Strong Menstrual Odor Ovarian Cysts Breast Lumps/Swellings

Vaginal Odor PCOS Positive Mammogram

Vaginal Discharge Fibroids Decreased Sex Drive

Vaginal Dryness Endometriosis Hot Flashes

Urinary Tract Infection Positive PAP smear Sexually Transmitted Disease

Other (please specify)      

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| **MALE REPRODUCTIVE** |

Age of 1st Ejaculation       Masturbation frequency       Sex frequency

Waking erection (freq)       Erection (poor – good)       Ejaculation Yes No

Abstinence Sexual dysfunction Impotence

Semen analysis (please describe results)

Other (please specify)

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| **MUSCULO-SKELETAL** |

Neck Pain Back Pain Sciatica

Muscle Pain Foot/Ankle Pain Arthritis

Hip Pain Hand/Wrist Pain Hernia

Muscle Weakness Knee Pain Swollen Joints

Poor posture Shoulder Pain Hot Joints

Other (please specify)

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| **NEUROLOGICAL and PSYCHOLOGICAL** |

Seizures Dizziness Loss of Balance

Areas of Numbness Poor Memory Lack of Coordination

Concussion Depression Anxiety

Tremors, ticks etc Easily Stressed Agitated/irritable

Treated for psychological issues Easily angered Attempted Suicide

Other (please specify)

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| **BIRTH, INFANCY, CHILDHOOD HISTORY** |

Please provide as much information as you have available. Talk to family members to fill in the gaps. For each question, check “Yes, “ “No,” or “Unsure,” and in addition report as much detail as you can.

1. **Prior to Pregnancy**

1. Did your mother or father drink excessive amounts of alcohol during the three month period prior to your conception? Yes No Unsure

If yes, please describe

2. Age at conception: a) of father      , b) of mother

4. If siblings, what number child are you      . List number of years between siblings.

1. Did your mother have a prior history of miscarriages? Yes No Unsure

If yes, please describe

1. Was your mother exposed to toxins or chemicals around the time of conception?

Yes No Unsure If yes, please describe

1. **During Pregnancy**

1. Did your mother have any illnesses during pregnancy?

nausea/vomiting  cancer  eclampsia/hypertension

placenta previa  heart defect  AIDS

rubella in 1st trimester  edema  other (please describe)

If yes or other, please describe

2. Did she experience any emotional shock or stresses?

death of someone close  loss of job  divorce

trauma or abuse  other (please describe)

If yes or other, please describe

3. Did she have adequate nutrition? Yes No Unsure

4. Was she on any medications? Yes No Unsure

Please list

5. During pregnancy, did she use  alcohol  cigarettes  other drugs or chemicals

Please list

6. Did she spend significant time in the presence of a smoker?  Yes  No Unsure

Describe any other conditions, habits, traumas (emotional or physical, i.e., falls, accidents) that might have affected the pregnancy.

1. **During Delivery**
2. Was birth:  early  late  on time Unsure

If early/late, by how many days/weeks?

1. Nature of birth  Vaginal  C-section
2. Presentation  Normal  O-P  Breech
3. Was labor of  natural onset  induced Unsure

If induced, by what method?

1. How long of a time elapsed between first contraction and delivery? If actual time is not known, descriptive words such as very fast or very long will do.
2. Was the birth traumatic to you or to your mother? Yes No Unsure

Forceps  Cold or shivering  Extreme pain

Excessive bleeding  Epidural  Other (explain)

If yes, please describe

1. Describe any unusual circumstances surrounding your birth

Breech  Cord wrapped around neck  Forceps

Born blue  Stuck in birth canal  Jaundiced

Umbilical or other hernia  Other (explain)

If yes, please describe

1. Was your mother kept in the hospital beyond the usual post-delivery period?

Yes No Unsure

If yes, please describe

1. Were you kept in the hospital beyond the usual post-delivery period?

Yes No Unsure

If yes, please describe

1. Were you placed in an incubator after birth?

Yes No Unsure If yes, please describe

1. **Your Infancy**
2. Was your general state of health at birth and during the first few months of your life

Good  Fair  Poor

1. Nutrition: Were you:  breastfed  bottle-fed  combination

If breast-fed, how long?

Describe any special information about your nutrition as an infant (allergies, special formula, etc.)

Did you experience colic? Yes No Unsure If yes, please describe

1. Were there any emotional or physical traumas in your infancy to you or members of your close family?

Yes No Unsure If yes, please describe

1. Did you receive normal pediatric immunizations? Yes No Unsure

If no, please describe

1. Sleep Patterns: Please describe any unusual sleep patterns
2. Other illnesses or hospitalizations
3. **Childhood**
4. Did you have any recurring health problems in childhood?

Earaches  Colds and sore throats  Digestive problems

Tonsils removed  Musculo-skeletal problems  Developmental problems

If yes or other, please describe

1. Did you have any major illnesses other than the usual childhood illnesses?

Yes No Unsure If yes, please describe

1. Were you able to engage in normal physical activities commensurate with your age?

Yes No Unsure Please describe any variations

1. Did you have any learning disabilities during childhood?

Yes No Unsure If yes, please describe

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| **TRAUMA HISTORY** |

1. In infancy, childhood or adolescence did you experience any of the following?

Neglect  Abandonment  Separation form family

Emotional abuse  Physical abuse  Sexual abuse

Any other form of abuse

If yes, please describe

1. In infancy, childhood or adolescence did you?

Experience the death of a parent or loved one  Have parents who divorced

Other stress in the household

If yes, please describe

1. At any other point in your life have you experienced or been?

Emotional abuse  Physical abuse  Sexual abuse

Victim of a crime  Death of life partner  Divorced

Other trauma (please describe) If yes, please describe