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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