|  |
| --- |
| **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? Yes; No

|  |
| --- |
| **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

Sexually Transmitted Diseases Thyroid Disease Hospitalizations

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 (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

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

Coffee Caffeinated Beverages Tobacco

Black Tea Alcohol

Substance use (specify)       Addictions (specify)

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

Exercise (specify type)

|  |
| --- |
| **MEDICATIONS and SUPPLEMENTS** |

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

|  |
| --- |
| **Previous Hospitalizations** |

Please specify (date and procedure)

|  |
| --- |
| **GENERAL HEALTH** and **REVIEW OF SYSTEMS** |

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

|  |  |  |
| --- | --- | --- |
| **General Symptoms** | **Skin** | **Urogenital** |
| Headache – migraine | Skin eruptions | Frequent urination |
| Thirst | Clammy skin | Scanty urination |
| Fainting | Dryness | Painful urination |
| Poor sleep – insomnia | Bruises easily | Blood in urine |
| Fatigue | Rashes | Cloudy urine |
| Abnormal sweating | Sensitive skin | Difficult to hold urine |
| Loss of weight | Hives | Stress incontinence |
| Fever | Itchy skin | Kidney/bladder infections |
| Chills – feels cold | Jaundice | Kidney stones |
| Cold hands and feet | Changes in moles |  |
| Hot hands and feet |  | **Gastrointestinal** |
|  | **Respiratory** | Poor appetite |
| **Neurological** | Chronic cough | Excessive hunger |
| Forgetfulness | Productive cough | Belching |
| Confusion | Chest pain | Heart burn, acid reflux |
| Poor memory | Difficulty breathing | Gas |
| Dizziness | Wheezing | Nausea or vomiting |
| Convulsions |  | Stomach pain or distention |
| Paralysis | **Cardiovascular** | Constipation |
| Tremors | Irregular heart beat | Diarrhea, Colitis |
| Numbness | High blood pressure | Blood in stool |
|  | Low blood pressure | Hemorrhoids |
| **Eyes, Ears, Nose and Throat** | Chest pain |  |
| Failing vision | Heart trouble | **Female** |
| Near sighted | Hardening of arteries | Painful menstrual periods |
| Eye pain | Swelling of ankles | Excessive flow |
| Cross eyed | Poor circulation | Irregular cycle |
| Eye inflammation | Varicose veins | Abnormal bleeding |
| Glaucoma |  | Vaginal discharge or pain |
| Deafness | **Muscles and Joints** | Breast pain |
| Loss of hearing | Neck Pain | Breast lumps |
| Ear discharge | Back Pain | Menopausal symptoms |
| Ringing in ears | Hip Pain | Reduced sex drive |
| Nose bleeds | Knee Pain |  |
| Nasal obstruction | Foot/Ankle/Leg Pain | **Male** |
| Nasal drainage | Hand/Wrist/Arm Pain | Genital pain |
| Loss of smell | Shoulder Pain | Reduced sex drive |
| Sinusitis | Sciatica | Premature ejaculation |
| Allergies | Pins and needles | Impotence |
| Sore throat | Swollen joints | Nocturnal seminal emission |
| Hoarseness | Hot joints |  |
| Difficulty speech | Arthritis | **Psychological** |
| Difficulty swallowing | Sore muscles | Depression |
| Change in tastes | Weak muscles | Anxiety – nervousness |
| Dental decay | Hernia | Panic attacks |
| Gum problems | Pain while walking | Nightmares |
| Asthma | Bad posture | Difficulty concentrating |
| Frequent colds | TMJ | Treatment – counseling, therapy |