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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? [ ] Yes; [ ] No

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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)       [ ] Addictions (specify)

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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| **Previous Hospitalizations**  |

Please specify (date and procedure)

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| **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  |