CONFIDENTIAL PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

BEST PHONE TO REACH: _____ EMAIL_____

IN CASE OF EMERGENCY: _____ PHONE _____

OCCUPATION:_____ MARITAL STATUS:_____

SOCIAL SECURITY # _____ (ONLY NECESSARY IF BILLING INSURANCE)

HOW DID YOU FIND ME? WERE YOU REFERRED HERE BY SOMEONE? _____

HAVE YOU EVER TRIED ACUPUNCTURE OR CHINESE HERBAL MEDICINE BEFORE? _____

WHAT ARE THE MAIN PROBLEMS YOU WANT TREATMENT FOR?

1. _____ FOR HOW LONG? _____

HAVE YOU BEEN GIVEN A DIAGNOSIS? _____

WHAT OTHER TREATMENTS HAVE YOU TRIED? _____

2. _____ FOR HOW LONG? _____

HAVE YOU BEEN GIVEN A DIAGNOSIS? _____

WHAT OTHER TREATMENTS HAVE YOU TRIED? _____

3. _____ FOR HOW LONG? _____

HAVE YOU BEEN GIVEN A DIAGNOSIS? _____

WHAT OTHER TREATMENTS HAVE YOU TRIED? _____

PAST MEDICAL HISTORY: AGE _____ HEIGHT:_____ WEIGHT:_____

ALLERGIES: (include reaction) _____

SIGNIFICANT ILLNESS, ACCIDENTS AND SURGERIES: (include dates) _____

_____

_____

_____

ARE YOU OR COULD YOU BE PREGNANT? _____

HAVE YOU EVER FAINTED? _____ FEAR OF NEEDLES? _____

CURRENT MEDICATION / SUPPLIMENT LIST:

MEDICATION	DOSE / FREQUENCY	REASON TAKING

TELL ME ABOUT YOUR HEALTH:
GENERAL: (Check any that are current problems or significant in your history, we will discuss)

POOR APPETITE	WEIGHT GAIN	NIGHT SWEATING
INSOMNIA	WEIGHT LOSS	SWEAT EASILY
DISTURBED SLEEP	CHANGE IN APPETITE	CHILLS
WEAKNESS IN LIMBS	CRAVINGS	FEVERS
EASY TO BE COLD	STRONG THIRST	FREQUENT COLDS
EASY TO BE HOT	EASY BRUISING	FATIQUE

SKIN AND HAIR:

RASHES	ECZEMA	RECENT MOLES
ULCERATIONS	PIMPLES	HIVES
ITCHING	DANDRUFF	HAIR LOSS
OTHER:	PSORISIS	VITALIGO

HEAD, EYES, EARS, NOSE, THROAT:

DIZZINESS	SPOTS IN VISION	SORE THROAT
CONCUSSIONS	COLOR BLINDNESS	TEETH GRINDING
MIGRAINES	BLURRY VISION	TEETH PROBLEMS
HEADACHES	EARACHES	FACIAL PAIN
EYE PAIN	RINGING IN EARS	JAW CLICKS
POOR VISION	POOR HEARING	SORES ON LIPS

NIGHT BLINDNESS	SINUS PROBLEMS	SORES ON TONGUE
EYE STRAIN	NOSE BLEEDS	PAINFUL TONGUE

CARDIOVASCULAR:

CHEST PAIN OR PRESSURE	HIGH BLOOD PRESSURE	LOW BLOOD PRESSURE
DIZZINESS	SWELLING OF FEET	FAINTING
IRREG. HEARTBEAT	SWELLING OF HANDS	BLOOD CLOTS
SHORT OF BREATH	COLD HANDS/ FEET	VARICOSE VEINS

RESPIRATORY:

ASTHMA	COUGH UP BLOOD	PHLEGM
BRONCHITIS	PNEUMONIA	CHRONIC COUGH
DIFFICULTY BREATHING WHEN LYING DOWN	SLEEP APNEA	EMPHYSEMA

GASTROINTESTINAL:

NAUSEA	ULCERS	RECTAL PAIN
VOMITING	BLACK STOOLS	HEMORRHOIDS
DIARRHEA	BLOOD IN STOOLS	ABDOMINAL PAIN
CONSTIPATION	INDIGESTION	USE LAXATIVES
BLOATING/ GAS BELCHING	BAD BREATH	SWALLOWING PROBLEM

URINARY:

PAIN WITH URINATION	URGENT / FREQUENT URINATION	UNABLE TO HOLD URINE
BLOOD IN URINE	KIDNEY STONES	POOR FLOW
FREQUENT BLADDER INFECTIONS	PROSTATE PROBLEMS	FREQUENT NIGHT URINATION

MUSCULOSKELETAL:

NECK PAIN	BACK PAIN	LEG PAIN
MUSCLE PAIN	MUSCLE WEAKNESS	TINGLING
SHOULDER PAIN	KNEE PAIN	FOOT/ ANKLE PAIN

HIP PAIN	FIBROMYALGIA	HAND/ WRIST PAIN

PSYCHOLOGICAL:

EASY ANGER	POOR MEMORY	FAMILY STRESS
FRUSTRATION	GRIEF / LOSS	WORK STRESS
BIPOLAR	WORRY OFTEN	RELATIONSHIP ISSUE
FEARFUL	DEPRESSION	UNCLEAR THINKING
ANXIETY	ADDICTIONS:	DISTURBING THOUGHTS

NEUROLOGICAL

SEIZURES	NUMBNESS	TREMORS
DIZZINESS	CONCUSSION	STROKE
LOSS OF BALANCE FALLS	CONFUSION	TRANSIENT ISCHEMIC ATTACKS

WOMEN ONLY:
FEMALE POST MENOPAUSE

AGE MENOPAUSE:	HOT FLASHES	NIGHT SWEATING
IRRITABLITY	ANXIETY	BODY ACHES

REPRODUCTIVE: FEMALE:

AGE OF FIRST MENSES :	BIRTH CONTROL:	NUMBER OF PREGNANCIES:
REGULAR CYCLES:	PMS IRRITABLITY	LIVE BIRTHS:
FLOW:	PMS BLOATING	MISCARRIAGES:
PAINFUL MENSES	PMS BREAST SORENESS	HERPES: OTHER:

THANK YOU FOR COMPLETING THIS FORM. IS THERE ANYTHING ELSE I SHOULD KNOW?

_____

_____

PLEASE SIGN BELOW:

NAME____ DATE ___________________