Patient Information

Patient's Name_____Today's Date_____
Birth Date_____Height_____Weight_____
Street Address_____ Apt. #_____
City_____State_____
Zip_____
Home Phone_____Office_____Other Phone_____
Email_____
Gender_____
MD's Name_____MD's Phone_____

__ single __ married __ divorced __ widowed __ domestic partnership __ other

Referred
by_____

Employment -Please check all that apply
__ full-time __ part-time __ self-employed __ student __ unemployed __ retired

Occupation_____Number of hours of work/study per week___

Billing and Insurance
Payment in full is due at the time services are rendered.

If you are covered by insurance, please bring your insurance card with you to your first visit.

Will you need a receipt or Superbill? __ No, thanks! __ Once a month __ At the end of each treatment

Missed Appointment Policy
If you need to change or cancel your appointment please do so with 24 hours notice. Failure to do so will result in a fee.

__ I understand cancellation policy.

Confidentiality
Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Health History
Reason for today's appointment/ Major Complaint_____
_____
_____
Other Complaints_____
_____
_____
When did you first notice this problem?
_____
How long have you had this condition?
_____
What makes it better?
_____
What makes it worse?
_____
Is your condition __Getting worse __Getting better __Constant __Comes & Goes
Western Diagnosis (if known):
_____
Medications/Herbs/Supplements you are currently taking:_____
_____
_____
_____
_____
Medication allergies_____
Don't know □
List Surgeries/Operations you have had and dates:_____
_____
_____

Have you had an acupuncture treatment before? If so, for what reason?
_____
_____
_____
_____

Family History: Please complete for each family member, placing an X in the appropriate box

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder disorder							
Drug / Alcohol Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

Other current related symptoms_____

_____

_____

_____

Energy Level ☐ High (time of day) _____ ☐ Low (time of day) _____

Stress ☐ None ☐ Moderate ☐ Severe What causes it?_____

Skin ☐ Dry ☐ Itchy ☐ Moist/Clammy ☐ Boils ☐ Changing moles ☐ Cysts/tumors ☐Frequent rashes ☐ Acne
☐ Dry scalp ☐ Dry hair ☐ Bruises easily ☐ Skin puffy

Scars Please list all scars_____

Circulation Feelings of ☐ Hot ☐ Cold Where?_____
☐ Bleed easily ☐ Cold limbs Other_____

Sleep Problems ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Excess dreaming
Other:_____ How many hours do you sleep at night?_____

Head ☐ Headaches what area?_____ when?_____
☐ Dizziness ☐ Memory loss ☐ Loss of balance Other_____

Eyes ☐ Eye pain ☐ Dry eyes ☐ Blurred vision ☐ Darkness under eyes Other_____

Ears ☐ Poor hearing ☐ Earaches ☐ Ear infections / discharge ☐ Ringing / buzzing Other_____

Nose ☐ Frequent nose bleeds ☐ Sinus trouble ☐ Frequent colds Other_____

Throat ☐ Sore throat ☐ frequent sore throats ☐ hoarseness ☐ Difficulty swallowing ☐ Jaw problems
☐ Teeth / gum problems ☐ Swollen tongue Other:_____

Chest ☐ Hard to breath ☐ Wheezing ☐ Shortness of breath ☐ Mucous when breathing ☐ Trouble breathing at night ☐ Pain / pressure in chest ☐ Palpatations ☐ Persistant cough ☐ Coughing blood ☐ Coughing phlegm
☐ Other_____

Blood Pressure ☐ High ☐ Low Numbers_____ ☐ Do not know

Bowels ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucous in stools ☐ Hemorrhoids ☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems Number of bowel movements a day_____
☐ Other_____

Urine Color_____ Amount: ☐ Normal ☐ Too much ☐ Too little
Frequent Urination ☐ Daytime ☐ At night ☐ Strong smelling Urine ☐ Difficult to urinate
☐ Pain or burning when urinating ☐ Dribbling ☐ Blood in Urine ☐ Frequent infections ☐ Water retention
☐ Other_____

Neurological ☐ Nervousness ☐ Depressed ☐ Easily angered ☐ Easily irritated ☐ Frequently crying
☐ Worry / anxiety ☐ Mood swings ☐ Memory confusion ☐ Poor concentration ☐ Suicidal ☐ Tremors
☐ Numbness / tingling in limbs ☐ Poor coordination ☐ Feel weak and shaky ☐ Seizures ☐ Neuralgia (nerve pain)
☐ Shingles Other_____

Females Pregnant? ☐ Yes ☐ No Last monthly period_____ Last PAP test _____
Form of birth control ☐ None ☐ Pill Other_____
Age started menstrual cycle_____ Age stopped_____ ☐ Menstrual pain ☐ Low backache ☐ Irregular bleeding
☐ Clotting ☐ Heavy bleeding ☐ Light bleeding Color_____ ☐ Water retention
☐ Mood changes ☐ Missed periods ☐ Low or no sex drive ☐ painful breasts ☐ Hot flashes ☐ Food cravings
☐ Other_____
Discharges ☐ Yellow ☐ White ☐ Clear ☐ Odor ☐ Itching Other_____
# of Pregnancies _____ # of Deliveries_____ # of Miscarriages_____ # of Abortions____ # of Cesareans_____ Operations
☐ Cervix ☐ Uterus ☐ Ovaries Other___

Males ☐ Low sex drive ☐ Impotence ☐ Painful ejaculation ☐ Discharges ☐ Premature ejaculation
☐ Known prostate trouble Other_____

Digestion ☐ Stomach gas ☐ Lower bowel gas ☐ Heartburn ☐ Burning / belching ☐ Stomach pain
☐ Stomach cramps ☐ Nausea ☐ Vomiting ☐ Bad breath ☐ Sores in mouth ☐ Weight gain ☐ Weight loss
☐ Bitter / sour taste in mouth ☐ Abdominal bloating ☐ How long after eating?_____
Food allergies? ☐ Yes ☐ No If yes, to what?_____ ☐ Don't know

Appetite Excessive appetite ☐ Poor appetite ☐ Appetite keeps changing ☐ Feel tired or weak if a meal is missed ☐ Excessive thirst ☐ Never thirsty Other_____
Specific food cravings for ☐ Sweet ☐ Sour ☐ Spicy ☐ Salty ☐ Carbohydrates Other_____

Nutrition Please list some of your favorite foods_____

Do You ☐ Skip Breakfast ☐ Eat a snack ☐ Eat a hearty breakfast
How many meals a day do you eat?_____ When is your biggest meal?_____

Do you eat when worried or rushed? ☐ Yes ☐ No How often?_____
How many glasses of water do you drink in a day?_____ ☐ Filtered ☐ Bottled

Do You use Alcohol? ☐ Yes ☐ No Amount per week_____ Type_____
Tobacco? ☐ Yes ☐ No Packs per day_____ How many years?_____

Do You:
Eat fruits and vegetables at least twice a day ☐ Yes ☐ No Eat dairy or meat 2 or more times a day ☐ Yes ☐ No
Eat green vegetables at least twice a day ☐ Yes ☐ No Eat the same foods almost every day ☐ Yes ☐ No
Eat frequently between meals ☐ Yes ☐ No Eat when you are not hungry ☐ Yes ☐ No
Chew your food thoroughly ☐ Yes ☐ No Eat until you feel full ☐ Yes ☐ No
Drink juice or milk instead of water ☐ Yes ☐ No Occasionally go on a "crash" diet ☐ Yes ☐ No
Always add salt at the table ☐ Yes ☐ No

Please list your overall health concerns in order of importance:

Please describe any regular program of exercise:

Do you have a religious or spiritual practice? If so, please describe:

What are the top priorities in your life?

What are your goals for your health?

Please provide any additional information about yourself or your condition not covered by the above questions.