PATIENT CONFIDENTIAL INFORMATION

Name________________________________ Today's date_______________________
Address____
City, State, Zip____
E-mail____________________________
Home phone_______________________ Cell Phone___________________________
What is the best telephone number to reach you at?______________________________
Sex: ☐ M ☐ F Age:____________________ Birth date_______________________
Occupation______________________________________
Referred by______________________________________
Emergency Contact Name & Phone____

Primary reason(s) for your visit____
____

Have you had acupuncture before? ☐ Yes ☐No Chinese Herbal Medicine? ☐ Yes ☐ No
Are you under the care of a physician now? ☐ Yes ☐No If yes, for what?____________
Who is your physician?______________________ Physician's phone_______________
Other concurrent therapies____

Family Medical History

☐Allergies	☐ Arteriosclerosis	☐ Cancer	☐ Diabetes	☐ Seizures
☐Asthma	☐ Alcoholism	_______	☐ Heart Disease	☐Stroke
		_______	☐High Blood Pressure	☐Other

Your Past Medical History

☐Acne	☐Diabetes	☐Intestinal Disorder	☐Seizures
☐AIDS/HIV	☐Digestive disorder	☐ Lupus	☐Strep throat
☐Alcoholism	☐Ear/Sinus infections	☐Migraines	☐Stroke
☐Allergies	☐Eating disorder	☐Mononucleosis	☐Skin disorder
☐Anemia	☐Emphysema	☐Measles	☐Thyroid Disease
☐Appendicitis	☐Epilepsy	☐Multiple Sclerosis	☐Tuberculosis
☐Arteriosclerosis	☐Goiter	☐Mumps	☐Typhoid Fever
☐Asthma	☐Gout	☐Pacemaker	☐Ulcers
☐Autoimmune disorder	☐Heart Disease	☐Parasites	☐Venereal disease
☐Birth Trauma (your own birth)	☐Hepatitis	☐Pleurisy	☐Whooping Cough
	☐Herpes	☐Pneumonia	☐Other (specify)
☐Cancer	☐High Cholesterol	☐Polio	_________________
☐Chicken Pox	☐High Blood Pressure	☐Rheumatic Fever	_________________
☐Chronic Fatigue Syndrome	☐Insomnia	☐Scarlet Fever	
☐Depression			

Please answer the following:

Do you have a tendency to faint? Yes___ No___
Do you have a pacemaker? Yes___ No___
Are you HIV positive? Yes___ No___
Do you have hepatitis? Yes___ No___
Are you pregnant? Yes___ No___ Due Date_______________

Please list any major physical or emotional traumas (accidents, falls, abuse, etc.), hospitalizations or severe illnesses:____
____

Please list any past surgeries (include dates):____
____

Please list pharmaceutical drugs taken within the last year:____
____

Please list vitamins, herbs, and supplements taken within the last year:_____________________________
____

Diet & Lifestyle

Appetite ☐Low ☐Moderate ☐High
Thirst ☐Low ☐Moderate ☐High
How many glasses of water/liquid do you drink/day?______
I prefer ☐Hot ☐Cold foods and drinks
I tend to crave ☐sweets ☐sour ☐bitter ☐salty ☐spicy
I regularly consume ☐coffee ☐soft drinks ☐artificial sweeteners ☐sugar ☐white flour
☐dairy food ☐canned/frozen food ☐fast food

Average Daily Menu (optional)

Breakfast	Lunch	Dinner	Snacks
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Do you smoke tobacco? ☐no ☐yes, frequency_______
Do you drink alcohol? ☐no ☐yes, frequency_______
Do you smoke marijuana? ☐no ☐yes, frequency_______
Do you use other recreational drugs ☐no ☐yes, frequency________

Exercise & relaxation/meditation techniques practiced:
Type____ Frequency_____________
Type____ Frequency_____________

PRESENT SIGNS AND SYMPTOMS

Please check any of the following conditions you currently have, or have had in the past that you feel are a significant part of your medical history.

Cold/Flu

Date Started___________ □Chills □Fever □Muscle/body aches
□Sweating □Sneezing □Sore throat
□Ear congestion/ache □Chest congestion
Coughing: □Dry □Productive Nasal Discharge: □Green □Yellow □White □Clear
□Nausea □Vomiting □Diarrhea □Constipation

Metal

□Shortness of breath □Spontaneous sweating □Lack of sweating
□Catch colds/flues easily □Chronic cough
□History of dry skin, acne, or other skin condition__________
□History of asthma/bronchitis □Sadness

Water

□Low back pain □Weak/sore knees □Cold hands/feet
□Night sweating □Afternoon fever □Heel pain
□Fearful □Chronic sore throat □Poor hearing
□Frequent urination □Night time urination □Burning/painful urination
□History of urinary tract infections □Premature hair loss/graying of hair
□Poor memory/concentration Sex drive: □Normal □High □Low
Ear ringing: □high pitched □low pitched

Wood

□Easy to anger □Irritability □Moody
□Depression □Easily stressed □Vertigo/dizziness
□Rib pain Eyes: □red □dry □itchy □Spots in your field of vision
□Poor vision □Blurred vision □Swollen glands
□Grinding teeth □TMJ □Neck/shoulder tension
□Alternating constipation/diarrhea
Stress level □Low □Moderate □High
Headaches: How often__________________ Location___________________________
Pain quality_____________________________ Pain severity (1-10)_______

Fire

☐Insomnia ☐Dream-disturbed sleep ☐Heart palpitations
☐Chest pain ☐Irregular/rapid heartbeat ☐Anxiety
☐Mouth/tongue ulcers ☐Easily startled

Earth

☐Bloating after eating ☐Tired after eating ☐Abdominal distention
☐Nausea ☐Vomiting ☐Belching
☐Flatulence ☐Hiccup ☐Bad breath
☐Heartburn ☐Acid regurgitation
☐Constipation ☐Diarrhea ☐Intestinal pain/cramping
☐Burning anus/itchy anus ☐Hemorrhoid ☐Blood/mucous in stools
Bowel movements: #times/day______ loose_____ normal_____ hard_____
☐Bruise/bleed easily ☐Fatigue, What time of day?_________________
☐Lack of strength ☐Bodily Heaviness ☐Worry

Body Pain

Location____
Frequency____
Pain quality: Sharp_____ Dull_____ Moving______ Pain severity (1-10):__________
Is pain affected by weather?____