

Date: _____

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: M / F Height: _____ Weight: _____

Address: _____ City/State: _____ Zip code: _____

Best ph. number for reminder calls: _____ Email address: _____

Your occupation: _____ Relationship status: _____ Number of children: _____

Emergency Contact: _____ Phone: _____ Relationship to you: _____

Primary Care Physician: _____ Date of last visit: _____ Reason for visit: _____

Are you pregnant? N / Y How many weeks? _____ How did you hear about me? _____

Please identify the primary health concerns that have caused you to seek treatment in order of importance:

<u>Condition</u>	<u>When did it start?</u>	<u>How does this condition affect you?</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Past or current treatments for the above and their outcomes:

List major illnesses, emotional trauma, accidents and surgeries, including dates if possible:

List current contagious diseases: _____

List all medications and supplements you are currently taking and dosages: (attach an extra sheet if necessary)

List allergies/sensitivities and type of reaction:

Have you received acupuncture treatment or Chinese herbs in the past? No / Yes When? _____

Family Medical History: Please identify immediate blood relatives who have experienced the following conditions

<input type="checkbox"/> Addiction (type):	<input type="checkbox"/> Hay fever /hives:
<input type="checkbox"/> Autoimmune disorder (type):	<input type="checkbox"/> High Blood Pressure:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Kidney Disease:
<input type="checkbox"/> Cancer (type):	<input type="checkbox"/> Mental Illness :
<input type="checkbox"/> Diabetes (type):	<input type="checkbox"/> Obesity:
<input type="checkbox"/> Heart Disease:	<input type="checkbox"/> Stroke:

Lifestyle: Please check that which applies

Work Activity:	Exercise:	Energy for Daily Tasks:	Typical Stress Level:	Habits:
<input type="checkbox"/> Sitting	<input type="checkbox"/> None	<input type="checkbox"/> Low	<input type="checkbox"/> Low	<input type="checkbox"/> Smoke packs/day:
<input type="checkbox"/> Standing	<input type="checkbox"/> Moderate	<input type="checkbox"/> Sufficient	<input type="checkbox"/> Moderate	<input type="checkbox"/> Alcohol drinks/wk:
<input type="checkbox"/> Light Labor	<input type="checkbox"/> Daily	<input type="checkbox"/> Good	<input type="checkbox"/> High	<input type="checkbox"/> Caffeine cups/day:
<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> Heavy	<input type="checkbox"/> Hyper	<input type="checkbox"/> Very High	<input type="checkbox"/> Other:

How is your sleep? _____ How many hours/night? _____ Wake feeling rested? Y / N

Health Systems: Please check any symptoms you have experienced in the last 3 months:

<p>GENERAL</p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Energy drop Time: _____ <input type="checkbox"/> Sweats easily <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Change in appetite <input type="checkbox"/> Change in thirst <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain _____lbs over _____months <p>SKIN & HAIR</p> <input type="checkbox"/> Rash <input type="checkbox"/> Dry skin <input type="checkbox"/> Hives <input type="checkbox"/> Acne or pimples <input type="checkbox"/> Itching <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Loss of hair <input type="checkbox"/> Dandruff <input type="checkbox"/> Sores <p>HEAD</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Head injury <p>EYES</p> <input type="checkbox"/> Impaired vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Dry eyes <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Double vision <input type="checkbox"/> Floaters <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <p>NOSE & SINUS</p> <input type="checkbox"/> Frequent colds <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Stuffiness <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Hay fever <p>EARS</p> <input type="checkbox"/> Impaired hearing <input type="checkbox"/> Earaches <input type="checkbox"/> Discharge <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing	<p>MOUTH & THROAT</p> <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Dental cavities <input type="checkbox"/> Gum problems <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Hoarseness <input type="checkbox"/> Swollen glands <input type="checkbox"/> Sores on lips or tongue <p>RESPIRATORY</p> <input type="checkbox"/> Persistent cough <input type="checkbox"/> Asthma / wheezing <input type="checkbox"/> Pain on breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Phlegm / sputum <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Emphysema <p>CARDIOVASCULAR</p> <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Swelling in ankles/ hands <input type="checkbox"/> Cold hands/ feet <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily <input type="checkbox"/> Bleed easily <input type="checkbox"/> Deep leg pain <p>GASTROINTESTINAL</p> <input type="checkbox"/> Heartburn <input type="checkbox"/> Gas & bloating <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Loose stools <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Hemorrhoids <p>URINARY</p> <input type="checkbox"/> Pain on urination <input type="checkbox"/> Increased frequency <input type="checkbox"/> Frequency at night <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Inability to hold urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent infections	<p>NEUROLOGIC</p> <input type="checkbox"/> Vertigo <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Paralysis <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Numbness/ tingling <input type="checkbox"/> Poor memory <input type="checkbox"/> Concentration problem <input type="checkbox"/> Poor balance <p>ENDOCRINE</p> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Sugar cravings <p>EMOTIONAL</p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> Bad temper <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Tendency to ruminate or over analyze <input type="checkbox"/> Addiction <p>MUSCULOSKELETAL</p> <input type="checkbox"/> Joint pain & stiffness <input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Neck pain <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Wrist pain <input type="checkbox"/> Upper back pain <input type="checkbox"/> Lower back pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Foot / ankle pain <input type="checkbox"/> Broken bone <p>MALE REPRODUCTIVE</p> <input type="checkbox"/> Hernias <input type="checkbox"/> Testicular mass <input type="checkbox"/> Testicular pain	<input type="checkbox"/> Prostate disease <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Diminished sex drive <input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> STDS <input type="checkbox"/> Discharge <p>FEMALE REPRODUCTIVE</p> Age menses began _____ Ave # of days _____ Length of cycle _____ Date last period began: _____ <input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> PMS <input type="checkbox"/> Painful intercourse <input type="checkbox"/> STDS Birth control type _____ # of pregnancies _____ # of live births _____ # of miscarriages _____ <input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Ovaries removed <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Menopause Age _____ Year _____ <input type="checkbox"/> Decreased vaginal lubrication <input type="checkbox"/> Diminished sex drive <hr/> What do you typically eat? AM: Lunch: PM: Snacks: Water intake:
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