

Appointment Date:

General Information

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Married Single Partner Divorced Widowed Date of Birth _____ SS# _____
Work Phone _____ Home Phone _____ Mobile Phone _____
Email _____ Occupation _____
Emergency Contact _____ Referred By _____
Family Physician _____ Contact # _____
Have you had Acupuncture or Oriental medicine before? Yes No
Are you presently under a doctor's care? Yes No Who and for what? _____
Are there any other therapies which you are involved in? Who and for what? _____

Insurance Information

Insurance Company _____ Contact # _____
ID # _____ Co-pay \$ _____ Visit # _____ Referral Yes No Covered % _____
Date called _____ Contact Name _____ Deductible amount _____

FOCUS

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities? Work Standing Sexually Other
 Sleep Emotional Recreation
 Walking Relationships Bending
 Sitting Social Life Stretching

What have you done about this? _____

Are you interested in: Pain Relief Performance Care Maintenance Care Other
 Preventative Care Holistic Health Stress Relief
 Oriental Nutrition Meridian Yoga Herbal Therapy

What are your health goals? _____

List any past or future surgeries. _____

List any significant trauma. When did it occur? (auto accident, falls, emotional, sexual, etc...) _____

List exercise and sport activities you have been or are currently involved in: _____

Signs/Symptoms

- | | | | | |
|---|---|---|---|---|
| <input type="radio"/> Abdominal pain/distention | <input type="radio"/> Coughing blood | <input type="radio"/> Hemorrhoids | <input type="radio"/> Mucous in stools | <input type="radio"/> Seizures |
| <input type="radio"/> Abuse survivor | <input type="radio"/> Dark stools | <input type="radio"/> Heart palpitations | <input type="radio"/> Muscle cramps/pain | <input type="radio"/> Seeing a therapist |
| <input type="radio"/> Acid regurgitation | <input type="radio"/> Decreased libido | <input type="radio"/> Hiccup | <input type="radio"/> Nasal congestion | <input type="radio"/> Short temper |
| <input type="radio"/> Acne | <input type="radio"/> Depression | <input type="radio"/> High blood pressure | <input type="radio"/> Neck/shoulder pain | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Asthma | <input type="radio"/> Dizziness/vertigo | <input type="radio"/> Impotence | <input type="radio"/> Night sweat | <input type="radio"/> Sinus pressure |
| <input type="radio"/> Bad breath | <input type="radio"/> Dry throat/mouth | <input type="radio"/> Increased libido | <input type="radio"/> Nocturnal emission | <input type="radio"/> Skin fungal infection |
| <input type="radio"/> Blood in stools | <input type="radio"/> Diarrhea | <input type="radio"/> Indigestion | <input type="radio"/> Nose bleeds | <input type="radio"/> Spots in eyes |
| <input type="radio"/> Blood in urine | <input type="radio"/> Ear aches | <input type="radio"/> Intestinal pain/cramps | <input type="radio"/> Numbness | <input type="radio"/> Sweat easily |
| <input type="radio"/> Blurry vision | <input type="radio"/> Enlarged thyroid | <input type="radio"/> Irritable | <input type="radio"/> Odorous stools | <input type="radio"/> Sore throat |
| <input type="radio"/> Breast lump/pain | <input type="radio"/> Eye pain/strain/tension | <input type="radio"/> Itchy eyes | <input type="radio"/> Pain upon urination | <input type="radio"/> Sudden energy drop |
| <input type="radio"/> Bruise easily | <input type="radio"/> Excessive phlegm | <input type="radio"/> Itchy skin | <input type="radio"/> Peculiar tastes | <input type="radio"/> Swollen glands |
| <input type="radio"/> Chest pains | <input type="radio"/> Excessive saliva | <input type="radio"/> Joint pain | <input type="radio"/> Poor appetite | <input type="radio"/> Teeth/gum problems |
| <input type="radio"/> Chills | <input type="radio"/> Fatigue | <input type="radio"/> Kidney stones | <input type="radio"/> Poor circulation | <input type="radio"/> Ulcerations |
| <input type="radio"/> Cold hands/feet | <input type="radio"/> Fever | <input type="radio"/> Laxative use | <input type="radio"/> Poor memory | <input type="radio"/> Upper back pain |
| <input type="radio"/> Concussion | <input type="radio"/> Frequent urination | <input type="radio"/> Limited range of motion | <input type="radio"/> Poor sleep | <input type="radio"/> Urgent urination |
| <input type="radio"/> Confusion | <input type="radio"/> Gas/belching | <input type="radio"/> Loss of hair | <input type="radio"/> Premature ejaculation | <input type="radio"/> Vomiting |
| <input type="radio"/> Constipation | <input type="radio"/> Grinding teeth | <input type="radio"/> Low back pain | <input type="radio"/> Psoriasis | <input type="radio"/> Wake to urinate |
| <input type="radio"/> Cough | <input type="radio"/> Headache | <input type="radio"/> Migraine | <input type="radio"/> Rash | <input type="radio"/> Weight loss/gain |
| | | <input type="radio"/> Mouth sores | <input type="radio"/> Redness of eyes | <input type="radio"/> Wheezing |

Female Concerns

- Date of last menstruation _____ Is your cycle regular? Yes No Is your cycle painful? Yes No
- Have you ever been pregnant? Yes No Birth control? Yes No How long? _____
- PMS Clotting Vaginal sores Vaginal pain Discharge

Medical History

- Do you have any allergies? Yes No If so, to what? _____
- Do you take medication? Yes No If so what types and how often _____
- Do you take supplements? Yes No If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

- | | | | | |
|------------------------------------|---|--|---|--|
| <input type="radio"/> Pneumonia | <input type="radio"/> Drug reaction | <input type="radio"/> Mental breakdown | <input type="radio"/> Gonorrhea/Herpes | <input type="radio"/> Cancer |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Heart attack | <input type="radio"/> Jaundice | <input type="radio"/> HIV/Aids | <input type="radio"/> Mental illness |
| <input type="radio"/> Hepatitis | <input type="radio"/> Blood transfusion | <input type="radio"/> Parasites | <input type="radio"/> High/low blood pressure | <input type="radio"/> Hypo/hyper thyroid |
| <input type="radio"/> Diabetes | <input type="radio"/> Anemia | <input type="radio"/> Measles | <input type="radio"/> Heart disease | <input type="radio"/> Premature graying |
| <input type="radio"/> Epilepsy | <input type="radio"/> Arthritis | <input type="radio"/> Mumps | <input type="radio"/> Gout | <input type="radio"/> Seizures |
| <input type="radio"/> Kidney Stone | <input type="radio"/> Obesity | <input type="radio"/> Syphilis | | <input type="radio"/> Multiple Sclerosis |