

Please fill in the following information as completely as possible. In order for us to verify your insurance benefits we must have the information listed below. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME _____ DATE _____

ADDRESS _____

CITY/STATE/ZIP _____

HOMEPHONE _____ CELLPHONE _____

BIRTHDAY _____ AGE _____ MARITAL STATUS _____

PLACE OF EMPLOYMENT _____

WORK PHONE _____ EMAIL _____

How did you first learn about acupuncture? _____

Major Medical Complaint: _____

Medications/Dosage/Reason _____

Supplements/Dosage/Reason _____

Surgical History List all hospitalizations in the past 10 years and all relevant injuries and surgeries that may be relevant to your current condition

Please mark those illnesses that you have experienced in the past or are currently dealing with.

Cancer Heart disease Thyroid disease Diabetes Hepatitis
HIV/AIDS High blood pressure Other significant illness_____

Briefly describe your diet_____

Do you drink black coffee or black tea? How much?_____

Do you drink alcohol? How much?_____

Do you currently smoke cigarettes? How long and how many per day? If you have quit, how long has it been since you last smoked?_____

Do you exercise regularly? What type of exercise? How often?_____

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms. It is essential to indicate time on the symptoms.

Please indicate with one check (☐) any conditions that you sometimes experience; use two checks (☑☑) for those which often occur and three checks (☑☑☑) for symptoms that are a major concern.

H

- Hearing Loss
- Dizziness
- Lower Back Pain/Neck Pain
- Sinus Congestion
- Edema
- Darkness under the eyes
- Emotional instability
- Aversion to cold
- Hair thinning or loss
- Pre-mature aging
- Frequent urination
- Kidney stones
- Perspire very easily
- Weakness of the Legs/Knees
- Asthmatic Cough
- Rapid Weight Change
- Asthmatic Cough
- Loose teeth
- Reduced sexual energy
- Thyroid Problems
- Diabetes

W

- Headache
- Migraines
- Ringing in the ears
- Poor eyesight
- Eye infections
- Dry eyes
- Eczema
- Shingles
- Herpes Simplex
- Warts
- Nervousness
- Convulsions/Spasms
- Irritability
- Constipation
- Hemorrhoids
- Hepatitis
- Irregular Menstruation
- Painful Menstruation
- Ulcer
- Vomiting
- Gallstones
- Indecisiveness
- Fullness below ribs
- Shoulder/neck tension
- Insomnia 11pm-3am

F

- Dry Scalp
- Skin eruptions, rashes
- Cysts, tumors
- Ear infections
- Sore throat, tonsillitis
- Lymphatic swelling
- Hot/cold hands/feet
- Heart palpitations
- Aversion to heat
- Bitter taste in mouth
- Gum problems
- Nose bleed
- Facial redness
- Itching/burning skin
- Thirst
- Dark urine
- Nightsweats
- Blood clots

E

- Indigestion
- Flatulence
- Food Allergy
- Stomach ache/ulcer
- Diarrhea
- Anemia
- Hallitosis
- Mouth sores
- Heartburn
- Strong appetite
- Weak appetite
- Nausea
- Abdominal bloating
- Low body weight

M

- Bronchitis
- Asthma
- Shallow breathing
- Cough
- Sinus congestion
- Nasal infections

Other

- Fatigue
- Arthralgia
- Sciatica / nerve pain
- Cold hands/ feet
- Tendonitis
- Bursitis

Pain (please describe)

Other Comments
