PATIENT INFORMATION

NAME: ____ DATE: _______________

ADDRESS:_____________________________CITY_______________STATE_____

ZIP: ___________ EMAIL: ____

WE SEND OUT AN EMAIL ABOUT 6 TIMES A YEAR. WOULD YOU LIKE TO BE ON OUR MAILING LIST? Y/N _____

HOME TEL # _________________ WORK # ___________ MOBILE # __________

DATE OF BIRTH: ____________ MARITAL STATUS: ___________________

REFERED TO CLINIC BY: ____

EMERGENCY CONTACT: ________________ RELATIONSHIP: ______________

EMERGENCY CONTACT TEL # _________________

EMPLOYMENT:

OCCUPATION: ____

EMPLOYER'S NAME: ____

EMPLOYERS ADDRESS: ____

EMPLOYER'S TEL # ______________________________

PHYSICIAN CONTACTS:

PRIMARY CARE PHYSICIAN: ____

TEL # _____________________________________

PLEASE LIST BELOW THE NAMES, SPECIALTY, AND PHONE NUMBERS OF YOUR OTHER PHYSICIANS:

Patient Name: ________________________________ **Date:** ______________

Please tell me what you know about your family history in terms of illness and disease.

Self: ____

Mother: ____

Father: ____

Brothers and Sisters: ____

____

____

Major Hospitalizations – If you have ever been hospitalized for any serious medical illness or operation, write below the date and reason for hospitalization or surgery.

____

____

Previous Pregnancies

Total Pregnancies ____ Living ____ Ectopic ____ Miscarriages ____ Induced Abortions ___

Please list any over the counter or prescribed medications you take you are taking currently and on a regular basis. Please include the dosages and frequency: ______________________

____

Please list any vitamins, herbs and dietary supplements you are taking currently and on a regular basis. Please include dosages and frequency: ________________________________

____

Please list any allergies you have: ____

Please list your habits relating to caffeine, tobacco, alcohol and drug use. Please include approximate amounts and frequency per day, week or month. __________________________

____

Patient Name: ________________________________ **Date:** ______________

Have you ever had an acupuncture treatment? When and for what reason? _______________

____

Are you presently being treated for a medical condition? Please describe: ________________

____

Please briefly describe any chronic pain: ____

____

What primary health issue do you want treated? Please describe as fully as possible: ______

____

____

What other health issues do you want treated? __________________________________

____

____

Please describe your typical daily diet: meals and snacks: _____________________________

____

____

Do you have any particular food cravings or aversions? Please list: ______________________

____

Do you exercise regularly? What types of exercise do you do on a daily/weekly basis?

____

____

Do you have any lifestyle habits or hobbies? Please describe: ___________________________

____

GENERAL

past current

Poor Appetite
Excessive Appetite
Insomnia
Fatigue
Fevers
Night Sweats
Sweats Easily
Chills
Localized Weakness
Poor Coordination
Change in Appetite
Strong Thirst
Other ______________

SKIN AND HAIR

past current

Rashes
Hives
Itching
Eczema
Pimples
Dryness
Psoriasis
Tumors/Lumps
Other ______________

HEAD AND NECK

past current

Dizziness
Fainting
Neck Stiffness
Enlarged Lymph Glands
Headaches
Concussions
Other ________________

EARS

past current

Infection
Ringing
Decreased Hearing
Other _________________

EYES

past current

Blurred Vision
Visual Changes
Poor Night Vision
Spots
Cataracts
Glasses/Contacts
Eye Inflammation
Other _______________

CARDIOVASCULAR

past current

High Blood Pressure
Low Blood Pressure
Blood Clots
Palpitations
Fainting
Phlebitis
Chest Pain
Irregular Heart Beat
Cold Hands/Feet
Swelling/Edema
Other _____________

RESPIRATORY

past current

Asthma
Bronchitis
Frequent Colds
C.O.P.D.
Pneumonia
Coughing Blood
Production of Phlegm
Other _____________

GASTRO-INTESTINAL

past current

Nausea
Vomiting
Diarrhea
Belching
Bloody or Black Stool
Bad Breath
Rectal Pain
Hemorrhoids
Constipation
Pain or Cramping
Acid Reflux
Gall Bladder Disorder
Gas
Other _______________

GENITO-URINARY

past current

Kidney Stones
Pain on urination
Frequent Urination
Blood in Urine
Urgency to urinate
Other _______________

NOSE THROAT MOUTH

past current

Nose Bleeds
Sinus Infection
Hay Fever/Allergies
Recurring Sore Throat
Grinding Teeth/TMJ
Difficulty Swallowing
Other _______________

FEMALE

past current

U.T.I.s
Vaginal Infections
Pain/Itching Genitalia
Vaginal lesions/discharge
Pelvic Inflammatory Disease
Abnormal Pap Smear
Irregular Menstruation
Painful Menstruation
P.M.S.
Abnormal Bleeding
Menopausal Syndrome
Breast Lumps
Other ___________________

NEUROLOGICAL

past current

Seizures
Tremors
Numbness/Tingling
Pain
Paralysis
Other ________________

PSYCHOLOGICAL

past current

Depression
Anxiety/Stress
Panic Disorder
Irritability
Clinical Psychiatric Disorder
Other ___________________

INFECTION SCREENING (test positive)

past current

HIV
TB
Herpes: oral / genital
Hepatitis
Gonorrhea
Syphilis
Chlamydia
HPV
Other ___________________

MALE

past current

Genital pain/itching
Genital lesions/discharge
Impotence
Weak urinary system
Prostatitis/Enlarged Prostate
Testicular lumps/tumors
Other ___________________

Patient Name: ___________________________________ **Date:** _______________