Date_____

Personal Information

Name _____ Age _____ Sex _____

Address _____

_____

_____

_____

Home Phone _____ Work Phone _____

Date of Birth _____/_____/_____ Marital Status _____

Number and Ages of Children _____

Occupation _____

Family Physician Phone _____

Health Insurance _____

Does your insurance policy cover acupuncture? _____

*If yes, I can provide you with a super-bill so you can bill them directly.

Person to notify in an emergency _____

Phone number _____

Referred to this office by _____

Confidential Patient History

Reason for seeking medical care today:

_____

Describe your current symptoms: _____

_____

_____

_____

How long have you had the symptoms? _____

How did this condition develop? _____

_____

_____

_____

Have you had this condition or a similar condition before? If yes, please explain: _____

_____

_____

Have you received treatment for this condition? Yes No

What was the diagnosis? _____

_____

Describe the treatment you received: _____

_____

Treatment results: _____

_____

Other conditions you are concerned about: _____

_____

_____

Please list surgeries and major illnesses you have had including dates: _____

_____

_____

_____

Please list ALL medications you are taking:

Medication	Dosage	For what condition?	For how long?

Please indicate if you have had any of the following:

AIDS____ Diabetes _____ Mental Illness _____

Alcoholism____ Gallstones_____ Seizures _____

Arthritis ____ Heart Disease ____ Stroke_____

Asthma ____ Hepatitis ____ Thyroid disease____

Autoimmune disease ____ High Blood Pressure _____ Ulcers____

Cancer ____ Kidney stones____ Venereal disease ____

Describe your average daily diet:

Breakfast _____

Lunch _____

Dinner _____

Describe your daily usage of the following:

Coffee, tea_____ Sodas, diet or regular _____

Alcohol_____ Tobacco_____ Recreational drugs_____

Describe your exercise regimen _____

Symptom Review

Put one check by a symptom you sometimes experience, use two checks for those which often occur, and three checks for symptoms that are a major concern.

CIRCULATION
- ☐ Bruise easily
- ☐ Bleed easily
- ☐ Cold limbs
- ☐ Other

EARS
- ☐ Poor hearing
- ☐ Earaches
- ☐ Discharges
- ☐ Ringing
- ☐ Other

ENERGY LEVELS
- ☐ Low
- ☐ High
- ☐ Other

EYES
- ☐ Blurred vision
- ☐ Eyelid problem
- ☐ Pain
- ☐ Red, itchy eyes
- ☐ Other

GASTROINTESTINAL
- ☐ Excess thirst
- ☐ Never thirsty
- ☐ Excess appetite
- ☐ Digestive pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Colon problems
- ☐ Other

HEAD AND FACE
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory loss
- ☐ Other

HEART AND THORAX
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Chest tightness
- ☐ Low blood pressure
- ☐ Difficulty lying flat
- ☐ Other

MOUTH
- ☐ Gum problems
- ☐ Teeth problems
- ☐ Tongue problems
- ☐ Lip problems
- ☐ Jaw problems
- ☐ Unusual tastes
- ☐ Other

MUSCULOSKELETAL
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Back pain
- ☐ Leg pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Other

NEUROLOGICAL
- ☐ Nervousness
- ☐ Tremors
- ☐ Convulsions
- ☐ Numbness or tingling
- ☐ Poor coordination
- ☐ Nerve pain or neuralgia
- ☐ Other

NOSE
- ☐ Frequent colds
- ☐ Sinus trouble
- ☐ Bleeding
- ☐ Other

REPRODUCTIVE
- ☐ Cramps
- ☐ PMS
- ☐ Infertility
- ☐ Frequent miscarriage
- ☐ Endometriosis
- ☐ Amenorrhea
- ☐ < 25 day cycle
- ☐ > 35 day cycle

RESPIRATION
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling
- ☐ Pain
- ☐ Cough
- ☐ Phlegm
- ☐ Other

SKIN
- ☐ Rashes
- ☐ Dryness
- ☐ Moles or lumps that change
- ☐ Excess sweat
- ☐ Night sweat
- ☐ Rarely sweat
- ☐ Other

SLEEP
- ☐ Insomnia
- ☐ Drowsiness
- ☐ Excess dreams
- ☐ Other

THROAT
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Other

URINATION
- ☐ Frequent
- ☐ Difficulty
- ☐ Painful
- ☐ Nocturnal urination
- ☐ Bleeding
- ☐ Other