New Patient Information Form

Please fill out these forms as completely as possible. All information on this form is confidential and will not be released to third parties without your wriiten consent. Please print.

Patient

Full name				
Address				
City			State:	ZIP:
Date of birth			Age:	
Phone Numbers	Home:	Work:	Cell:	
Email Address		May we use email to contact you? Y N		
Social Security Number				
Occupation				
Emergency Contact & Phone				Blood Type
Have you had acupuncture before?				
Have you taken Chinese herbs before?				
Who may we thank for referring you to our office?				

Today's Visit

Today's Date	
Reason for today's visit?	
When did this condition start?	
Is it getting worse?	
How did it start?	
What seems to make it better?	
What seems to make it worse?	

Family Medical History: Please complete for each family member. Place an X in the box indicating any of the illnesses that they have ever had.

	Father	Mother	Brother	Sister	Children
Allergies					
Blood Disorder					
Diabetes					
Cancer					
Seizures					
High Blood Pressure					
Kidney Disease					
Stomach or Intestinal Disorder					
Drug Abuse					
Tuberculosis					
Heart Disease					
Stroke					
Psychiatric Illness					
Other					

Personal Medical History: Please check the box for any disorder you have ever had:

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies
- ❑ Appendicitis
- ❑ Arterioclerosis
- ❑ Asthma
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Drug Allergies
- ❑ Epilepsy
- ❑ Headaches
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ Hypertension
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Pneumonia
- ❑ Seizures
- ❑ STD
- ❑ Skin Disorders
- ❑ Stroke
- ❑ Thyroid Disorders
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Urinary Tract Disorder

Major Hospitalizations: If you have been hospitalized for any serious illness or surgery, please provide the information requested. Do not include normal pregnancies.

Hospitalizaton	Year	Illness/Surgery	Name of Hospital	City & State
Most Recent				
Next Most Recent				
Third Most Recent				

Please list any medications you are currently taking:

Name of Drug	Dosage

Do you have any drug allergies?

Please list any herbs, vitamins and nutritional products you are taking:

Name of Herb or Product	Why Are You Taking This?

Who is your current physician? Phone number? When did you last see him/her?

_____

Who will be financially responsible for this account? How will you pay for services?

_____

I have answered this questionaire to the best of my recollection and knowledge, and I hereby request and consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine. I understand that fees for treatment are due at time of service.

_____ _____

Date **Signature of Patient (or Guardian if patient is a minor)**

Please tell us a bit more about your health and symptoms you may be experiencing. Place a "C" next to any symptom you are currently experiencing, and a "P" next to symptoms you have had in the past.

General Symptoms

__ Insomnia
__ Frequent dreams
__ Agitation
__ Fatigue
__ Aversion to cold
__ Aversion to heat
__ Frequent urintation
__ Irritibility
__ Thirst

Skin

__ Hives
__ Rashes
__ Eczema
__ Night sweating
__ Excess sweating
__ Dryness
__ Bruise easily
__ Changes in mole or lump
__ Acne
__ Fungal infections

Head & Neck

__ Dizziness
__ Fainting
__ Neck stiffness
__ Enlarged lymph glands
__ Headaches
__ TMJ

Eyes

__ Blurred vision
__ Visual changes
__ Poor night vision
__ Spots
__ Eye inflammation
__ Eye strain

Ears

__ Ringing
__ Infection
__ Decreased hearing

Nose, Throat & Mouth

__ Bleeding
__ Sinus infection
__ Hay fever or allergies
__ Sore throat
__ Hoarseness
__ Difficulty swallowing
__ Changes in taste
__ Changes in smell
__ Oral ulcers

Respiratory

__ Chronic cough
__ Coughing up blood
__ Coughing up phlegm
__ Difficulty breathing
__ Wheezing
__ Asthma
__ Frequent colds

Cardiovascular

__ Palpitations
__ Chest pain or tightness
__ Rapid heart beat
__ Poor circulation
__ Swelling of ankles

Gastrointestinal

__ Nausea or vomiting
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Bloody or black stools
__ Hemorrhoids
__ Gallbladder disorder
__ Recent change in weight

Male Reproductive

__ Pain or itching of genitalia
__ Genital lesions or discharge
__ Impotence
__ Weak urinary system
__ Lumps in testicles
__ Low or excessive desire

Female Reproductive

__ Frequent urinary infections
__ Frequent vaginal infections
__ Pain or itching of genitalia
__ Genital lesions or discharge
__ Pelvic inflammatory disease
__ Abnormal PAP smear
__ Irregular menstrual periods
__ Painful menstrual periods
__ Premenstrual syndrome
__ Abnormal bleeding
__ Menopausal symptoms
__ Breast lumps

Age menses began _____
Duration of flow _____
Length of cycle _____
Date of last period _____

Muscle & Joint

__ Joint disorder
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Spinal curvature
__ Backache
__ Back pain

Neuropyschological

__ Seizures
__ Tremors
__ Numbness
__ Tingling of limbs
__ Pain
__ Paralysis
__ Poor memory
__ Depression
__ Anxiety
__ Abuse survivor
__ Considered/attempted suicide
__ Psychiatric Diagnosis

Lifestyle

__ Alcohol
__ Tobacco
__ Marijuana
__ Drugs
__ Stress
__ Occupationl hazards
__ Regular exercise
__ Hobbies