



Today's Date ____/____/____

Personal Information

Name:		First	Last	Middle
Date Of Birth:	Age:	Sex:		
____/____/____	()	(M / F / T)		
Address:	Street	City/State	Zip	
Telephone:	Home	Cell	Work	
	() -	() -	() -	
Email Address:				initial if it is OK to contact you via email
	@			_____
Status:	() Married () Single () Divorced () Widowed () Other _____			
How did you hear about us?	___Yelp ___newsletter ___Facebook ___website ___referral ___other _____			
Referred By:	Relationship:			
Occupation:	() Full Time () Part Time () Unemployed () Retired () Student			
Emergency Contact:	Relationship:		Phone	
			() -	

Recent Health History

What is the reason for your visit today? List in the order of significance.

Severe	Moderate	Slight
1. S	M	SL _____
2. S	M	SL _____
3. S	M	SL _____

How long have you had this condition? _____ Is it getting worse? Y / N

Does it bother your Sleep Work Other: _____

What seems to make it better? _____

What seems to make it worse? _____

Have you ever had acupuncture before? ___Yes ___No

If yes what were you treated for? _____

Have you ever had Chinese herbs before? ___Yes ___No

If yes what were you treated for? _____

Recent Health History

Date ____/____/____

Please list any physicians/therapist you are currently seeing or have seen in the recent past:

1. Name _____ Telephone _____

Reason for care _____ Still under care? ___ Yes ___ No

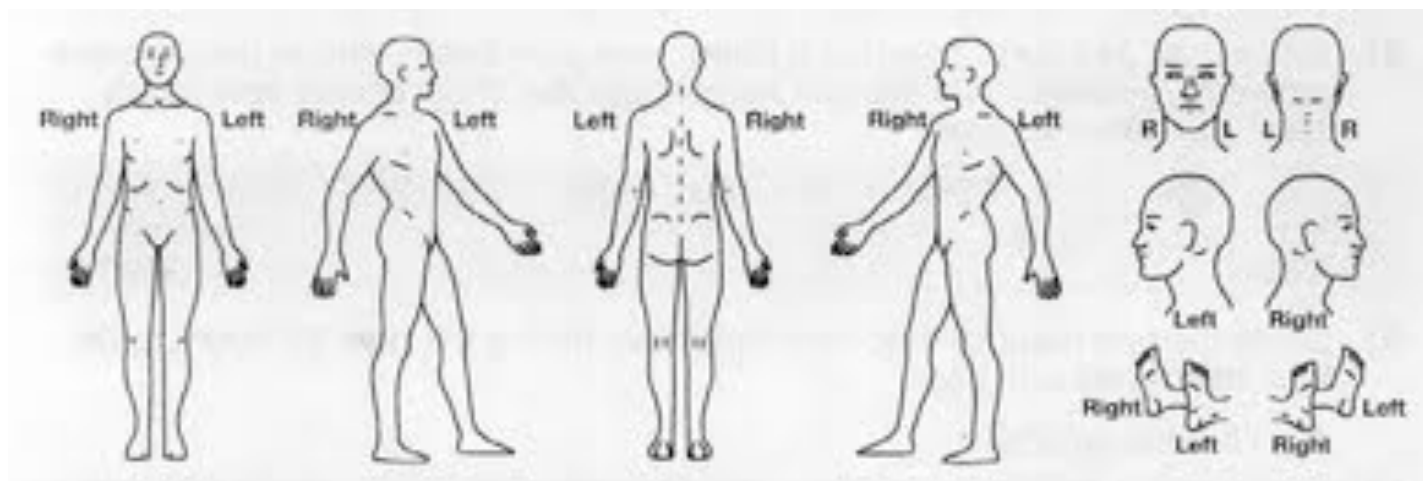
2. Name _____ Telephone _____

Reason for care _____ Still under care? ___ Yes ___ No

Please write any recent hospitalizations for serious injury or illness below

Month/Year	Operation or Illness	Name of Hospital	City and State

Are you experiencing pain/discomfort in any area of your body? Y / N



If yes, using the models above please indicate the location of the discomfort by using the symbol that best describes the feeling:

- X** Sharp/Stabbing
- P** Pins and Needles
- D** Dull/Aching
- N** Numbness

Please rate your pain on a scale of 1-10 _____

Allergies Please list

- Medications/Drugs _____
- Food _____
- Latex _____
- Other _____



For Women

1. Are you pregnant now? Yes No Unsure If yes, how many weeks? _____ due date _____
2. Indicate number of occurrences:
 Live Births _____ Pregnancies _____ Miscarriages _____ Abortions _____
3. Age: First period _____ Menopause (if applicable) _____
4. Date: Last Pap Smear ____/____/____ Last Mammogram ____/____/____
5. Any history of an Abnormal Pap Smear? Yes No If yes, what / when? _____
6. Is your menstrual cycle regular? Yes No
 - a) Average days of flow _____
 - b) The flow is: Normal Heavy Light
 - c) The color is: Normal Dark Purple Light Brown Dark Brown
7. Do you have the following menstruation related signs/symptoms?
 Difficulty with orgasm Cramps Heavy vaginal discharge between menses
 Pain with intercourse Nausea Bleeding between menses Vaginal discharge
 Blood clots PMS Breast distention Back pain

For Men

1. Do you have any bothersome urinary symptoms: Yes No

Describe: _____

2. Check all that apply

Erectile dysfunction Difficulty with orgasm Pain or swelling of testicles
 Impotence/erectile dysfunction Premature ejaculation Cold/numb genitalia Low back pain
 Incontinence Pain/subtly of testicles Frequent night urination

3. Do you get up at night to urinate? Yes No How often? _____

4. To what extent do these conditions interfere with daily activities (work, sleep, socializing, sex, etc.)?

5. Have you sought medical intervention for these problems? If so, when?

6. What treatments have you tried so for these problems and how successful have they been?



Medical History

Please check all that apply

Diabetes _____ / _____ / _____
 High Blood Pressure _____ / _____ / _____
 Thyroid Disease _____ / _____ / _____
 Cancer _____ / _____ / _____
 HIV _____ / _____ / _____

Date Diagnosed

Please check all that apply

High Cholesterol _____ / _____ / _____
 High Blood Pressure _____ / _____ / _____
 Seizures _____ / _____ / _____
 Hepatitis _____ / _____ / _____
 Others _____ / _____ / _____

Date Diagnosed

Family History

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart Disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

Medications/Supplements Please list **ALL** of the medication, herbs, and supplements that you are now taking

Medication	Purpose	Current Dosage	Date Started	Are you satisfied with results
		_____ per day/week		
		_____ day/week		
		_____ day/week		
		_____ day/week		
		_____ day/week		
		_____ day/week		
		_____ day/week		
		_____ day/week		
		_____ day/week		

Nutrition

1. Do you have a special diet? ___Yes ___No If yes, how would you describe the diet? (i.e. vegan, vegetarian, low carb, Atkins etc.)

2. What do you eat on a typical day?

- a) Breakfast _____
- b) Lunch _____
- c) Dinner _____
- d) Snacks _____
- e) Foods you tend to crave _____
- f) Foods you dislike _____

Social History

Coffee:	<input type="radio"/> YES <input type="radio"/> NO	Cups per day/week	Age Started	Age Quit
Tobacco:	<input type="radio"/> YES <input type="radio"/> NO	Use per day/week	Age Started	Age Quit
Alcohol:	<input type="radio"/> YES <input type="radio"/> NO	Use per day/week	Age Started	Age Quit
Marijuana:	<input type="radio"/> YES <input type="radio"/> NO	Use per day/week	Age Started	Age Quit
Narcotics	<input type="radio"/> YES <input type="radio"/> NO	Use per day/week	Age Started	Age Quit
Opiates	<input type="radio"/> YES <input type="radio"/> NO	Use per day/week	Age Started	Age Quit



Social History Continued

1. Have you ever had a problem with alcohol or alcoholism? Yes No
2. Have you ever had a problem with dependency on other drugs (or medications) Yes No
3. If yes when and which ones? _____
4. Do you have a known history of any exposure to toxic substances? Yes No
5. In the past year how many days have you been significantly affected by your health _____
6. How many days did you feel generally poor? _____
7. How many times were you hospitalized? _____
9. Please describe your current exercise regimen:
Hours per week: _____ Activities: _____ No exercise
10. Who would you describe your primary social support? (relationships to you) _____

Other Information Please list and briefly describe the most significant events in your life:

1. _____
2. _____
3. _____
4. _____

Have you been treated for emotional issues? Yes No

Have you ever considered or attempted suicide? Yes No

Do you have any other neurological or psychological problems? Yes No

Please provide us with any other information that you think is relevant:



General

Past	Current	Condition
[]	[]	Poor appetite
[]	[]	Excessive appetite
[]	[]	Insomnia
[]	[]	Fatigue
[]	[]	Night sweats
[]	[]	Sweat easily
[]	[]	Chills
[]	[]	Localized Weakness
[]	[]	Poor Coordination
[]	[]	Bleed or bruise easily
[]	[]	Catch colds easily
[]	[]	Change in appetite
[]	[]	Strong thirst
[]	[]	other_____

Skin & Hair

Past	Current	Condition
[]	[]	Rashes
[]	[]	Hives
[]	[]	Itching
[]	[]	Eczema
[]	[]	Pimples
[]	[]	Dryness
[]	[]	Tumors, lumps

Head and Neck

Past	Current	Condition
[]	[]	Dizziness
[]	[]	Fainting
[]	[]	Neck stiffness
[]	[]	Enlarged lymph glands
[]	[]	Headaches
[]	[]	Concussions
[]	[]	Other: _____

Ears

Past	Current	Condition
[]	[]	Infection
[]	[]	ringing
[]	[]	Decreased hearing
[]	[]	Other: _____

Eyes

Past	Current	Condition
[]	[]	Blurred vision
[]	[]	Visual changes
[]	[]	Poor night vision
[]	[]	Spots
[]	[]	Cataracts
[]	[]	Glasses/contacts
[]	[]	Eye inflammation
[]	[]	Other: _____

Nose, Throat, Mouth

Past	Current	Condition
[]	[]	Nose bleeds
[]	[]	Sinus infections
[]	[]	Hay fever/allergies
[]	[]	Recurring sore throat
[]	[]	Grinding teeth
[]	[]	Difficulty swallowing
[]	[]	Other: _____

Cardiovascular

Past	Current	Condition
[]	[]	High blood pressure
[]	[]	Low blood pressure
[]	[]	Palpitations
[]	[]	Phlebitis
[]	[]	Chest pain
[]	[]	Irregular heart beat
[]	[]	Cold hands/feet
[]	[]	Fainting
[]	[]	Difficult breathing
[]	[]	Swollen hands/feet
[]	[]	Other_____

Respiratory

Past	Current	Condition
[]	[]	Asthma
[]	[]	Bronchitis
[]	[]	Frequent colds
[]	[]	COPD
[]	[]	Pneumonia
[]	[]	Cough
[]	[]	Coughing blood
[]	[]	Phlegm

Gastro-Intestinal

Past	Current	Condition
[]	[]	Nausea
[]	[]	Vomiting
[]	[]	Diarrhea
[]	[]	Belching
[]	[]	Bloody/black stools
[]	[]	Bad breath
[]	[]	Rectal pain
[]	[]	Hemorrhoids
[]	[]	Constipation
[]	[]	Pain or cramps
[]	[]	Indigestion
[]	[]	Gallbladder disorder
[]	[]	Gas
[]	[]	other_____

Genito-Urinary

Past	Current	Condition
[]	[]	Kidney stones
[]	[]	Painful urination
[]	[]	Frequent urination
[]	[]	Bloody urine
[]	[]	Urgency to urinate
[]	[]	Unable to urinate
[]	[]	Incontinence
[]	[]	other_____

Male

Past	Current	Condition
[]	[]	Pain/itching genitals
[]	[]	Genital lesions
[]	[]	Genital discharge
[]	[]	Impotence
[]	[]	Weak urinary system
[]	[]	Prostatitis
[]	[]	other_____



Female

Past	Current	Condition
[]	[]	Frequent urinary tract infections
[]	[]	Frequent vaginal infections
[]	[]	Pain/itchy genitals
[]	[]	Pelvic inflammatory disease
[]	[]	Abnormal pap smear
[]	[]	Irregular periods
[]	[]	PMS
[]	[]	Abnormal bleeding
[]	[]	Menopause
[]	[]	Breast lumps
[]	[]	Hot flashes
[]	[]	other_____

Neurological

Past	Current	Condition
[]	[]	Seizures
[]	[]	Tremors
[]	[]	Numbness/tingling
[]	[]	Concussion
[]	[]	Pain
[]	[]	Paralysis
[]	[]	Other_____

Infection Screening

Past	Current	Condition
[]	[]	HIV
[]	[]	TB
[]	[]	Hepatitis
[]	[]	Gonorrhea
[]	[]	Chlamydia
[]	[]	Syphilis
[]	[]	Genital warts
[]	[]	Herpes: Oral
[]	[]	Herpes: Genital
[]	[]	Other_____

Psychological

Past	Current	Condition
[]	[]	Depression
[]	[]	Anxiety/stress
[]	[]	Irritability
[]	[]	In Therapy
[]	[]	Taking psych meds
[]	[]	Other_____

Muscular-Skeletal

Past	Current	Condition
[]	[]	Stiff neck/shoulders
[]	[]	Low back pain
[]	[]	Spasms, cramps
[]	[]	Twitching
[]	[]	Sore, weak knees
[]	[]	Joint pain
[]	[]	Burning/Shooting pain
[]	[]	Other_____