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• PATIENT INFORMATION FORM •

Please fill out as completely as possible. The information you include here is confidential, and will be used to help determine the best course of treatment for you. If you have questions about any items on the form, please ask. Thanks for your time.

Name			**Today's Date**
Street Address			
City		State	Zip
Home Phone		Email	
Occupation			Work Phone
Emergency Contact: Name			Phone
Who may I thank for referring you?			
Sex ○ Male ○ Female	Height	Weight	Birthdate
Have you received acupuncture or Chinese herbal therapy before? Yes ○ No ○			
Previous practitioner		When treated?	

Please list the major concern(s) that brought you here today:	
Concern	How long?
1. 2. 3. 4. 5.	
What other forms of treatment have you explored for these concerns?	

Please list any medications or nutritional supplements you are currently taking (use back of sheet if necessary):	
Name of medication/supplement	Dosage
Please describe your typical daily eating habits:	
Breakfast: Lunch:	Dinner: Snacks:
How many alcoholic beverages do you drink weekly?	
Are you a smoker? If so, how many times a day do you use tobacco?	
How many cups of coffee, tea or other caffeinated beverage do you consume daily?	
How much water do you drink daily?	

• Medical History •

Please indicate any history of the following illnesses or conditions in you or your family:

Illness	You	Family Member	When?	Illness	You	Family Member	When?
Cancer				Emotional Disorders			
Heart Disease				Tuberculosis			
High Blood Pressure				Seizures			
Diabetes				Stroke			
Thyroid Disorder				Neurological Disorders (e.g. Parkinson's)			
Hepatitis				Sexually Transmitted Diseases			
Congenital Disorders (from birth)				HIV/AIDS			

Please list any accidents, surgeries, or hospitalizations (include dates):

Other (please specify):

• Lifestyle Inventory •

How do you feel about the following aspects of your life? Please check the applicable box and include any relevant comments.

	Great	Good	OK	Poor	Bad	Comments
Life partner						
Family						
Diet						
Sex Life						
Self Image						
Work						
Exercise						
Spirituality						

Please rank the following statements as they apply to your life.
(1 = most important, 5 = least important):

___To be in control ___To be loved ___To be needed ___To be correct ___To be safe

• For Women Only •

Age of 1st period (menarche)	Are you pregnant? Yes No			# of pregnancies		
Age of last period (menopause)	# of live births		# of abortions		# of miscarriages	
# of days between periods	Date of last GYN exam:			Date of last Pap smear:		
# of days of flow	Date of last mammogram:			Date of last Bone density scan:		
Color of flow						
Clots? Yes No	Average # of pads you use per day of cycle:					
If yes, what color:	1st day	2nd day	3rd day	4th day	+ day(s)	

Have you been diagnosed with (circle all that apply):	Fibroids	Fibrocystic Breasts	Endometriosis	Ovarian Cysts	PID	Infertility	Other

Nature of menstrual pain (circle all that apply)	
Cramping	Stabbing
Burning	Aching
Dull	Bloating
Constant	Intermittent
Bearing Down Sensation	
Other:	

Location of Menstrual Pain (circle all that apply)
Lower Abdomen
Lower Back
Thighs
Side of Ribcage
Other:

Other symptoms related to menstrual cycle (circle all that apply)		
Vaginal Discharge	Vaginal Dryness	Headache
Nausea	Constipation	Diarrhea
Swollen Breasts	Mood Swings	Ravenous Appetite
Loss of Appetite	Hot Flashes	Night Sweats
Increased Libido	Decreased Libido	Insomnia
Other:		

• For Men Only •

Date of last prostate exam	PSA results	Manual prostate exam results
Frequency of Urination # of times during day: # of times after bedtime:	Color of Urine (circle one) Clear Pale yellow Yellow Dark yellow other	Other qualities noted (circle below) Unusual Odor Cloudy Bloody

Other symptoms (mark all that apply):

Delayed urine stream	Dribbling urination	Incontinence
Urinary retention	Rectal dysfunction	Back pain
Back pain	Groin pain	Testicular pain
Premature ejaculation	Erectile dysfunction	Other:
Increased libido	Decreased libido	

•Review of Body Systems•

Please indicate how often you notice the following symptoms. If you never experience a symptom, just leave it blank.

N = Now O = Often S = Sometimes R = Rarely

Group 1								
spontaneous sweating	N	O	S	R	feeling of sadness	N	O	S	R
allergies	N	O	S	R	catch colds easily	N	O	S	R
asthma	N	O	S	R	feel tired after exertion	N	O	S	R
shortness of breath	N	O	S	R	general weakness	N	O	S	R
cough	N	O	S	R	nasal discharge	N	O	S	R
dry nose/mouth/throat	N	O	S	R	sinus congestion	N	O	S	R
Group 2								
poor appetite	N	O	S	R	heavy limbs	N	O	S	R
loose stools	N	O	S	R	hemorrhoids	N	O	S	R
abdominal gas/bloating after food	N	O	S	R	belching	N	O	S	R
fatigue after eating	N	O	S	R	nausea	N	O	S	R
sinking feeling in uterus/belly	N	O	S	R	diarrhea	N	O	S	R
obsessive thoughts/worrying	N	O	S	R	craving for sweets	N	O	S	R
Group 3								
heart palpitations	N	O	S	R	red cheeks	N	O	S	R
insomnia	N	O	S	R	chest pain	N	O	S	R
mouth/tongue sores	N	O	S	R	disturbing dreams	N	O	S	R
anxiety	N	O	S	R	excessive/uncontrollable laughter	N	O	S	R
restlessness	N	O	S	R	excessive sweating	N	O	S	R
Group 4								
irritability	N	O	S	R	muscle spasms/twitches	N	O	S	R
feel better after exertion	N	O	S	R	heartburn/acid reflux	N	O	S	R
tight feeling in chest/rib side	N	O	S	R	bitter mouth taste	N	O	S	R
flank pain	N	O	S	R	dry/red eyes	N	O	S	R
alternating diarrhea/constipation	N	O	S	R	ear ringing	N	O	S	R
symptoms worse with stress	N	O	S	R	anger easily	N	O	S	R
neck/shoulder tension	N	O	S	R	feeling of sand in eyes	N	O	S	R
floaters in vision	N	O	S	R	hair loss	N	O	S	R
brittle or weak nails	N	O	S	R	frequent headaches	N	O	S	R
feeling of heat rushing to head	N	O	S	R					
Group 5								
sore, cold or weak knees	N	O	S	R	feeling cold	N	O	S	R
low back pain	N	O	S	R	edema	N	O	S	R
frequent urination	N	O	S	R	premature graying	N	O	S	R
urinary incontinence	N	O	S	R	memory loss	N	O	S	R
hearing loss	N	O	S	R	decreased sex drive	N	O	S	R
early morning diarrhea	N	O	S	R	hyperactive sex drive	N	O	S	R
craving salt	N	O	S	R	fatigue after sex	N	O	S	R
					infertility	N	O	S	R