

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

**Personal Information**

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**How We Use Email:** appointment reminders, checking progress, and our newsletter (monthly health tips, clinic news, promotions). You can opt out any time. Please add me to your address book to ensure receipt of emails. Yahoo puts us into spam, check that folder, or use another email address. Your email and all personal information is kept private.

Email (print clearly) \_\_\_\_\_

**Current Concerns**

List the primary reasons for your appointment. Include all current symptoms, concerns and health-related issues in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**By signing below, you are indicating that you agree and understand the following:**

- I will pay \$20 for *all* schedule changes I make with less than a 24-hour notice.
- I will refrain from wearing scented products to the clinic.
  - For example: perfume, cologne, lotions, wet nail polish, etc.
- I will not smoke for at least 3 hours before my appointment.

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Pain Section**

Do you have *any* pain? Where?

What happened? When? How?

How often is it present? How long does it last when it is present?

What is the intensity of the pain?

Have you had this before? When was the last time?

What makes it better / worse? Is there a change when lying, sitting or standing? -When walking, running, squatting, or rising? -With heat, cold, massage, exercise, or medication?

What sensations do you have: sharp, dull, throbbing, aching, numb, tingling, electric, etc.?

Where are you generally on a scale of 0 – 10, zero is no pain, 10 is the worst:

Does the pain restrict or stop activities?

Does the pain travel? If so, from where to where? How often does it radiate and for how long?

Does the pain change depending on your location (work, home, car, etc.)?

Is there a change based on the time of day: morning, late morning, afternoon, evening or night?

**Chinese Medicine Questions:** (Circle all that apply now)

**Appetite:** low / high / normal      **Energy:** low / high / normal / time of day \_\_\_\_\_

**Bowel:** soft / hard / loose / sticky      **Digestion:** gas / bloating / acid reflux

**Urine:** dark / light / at night # \_\_\_\_      **Sweat:** at night / easily with little effort

**Insomnia:** fall asleep / stay asleep      **Moods:** anxiety / depression / other \_\_\_\_\_

**Describe what you typically eat and drink for each:**

Breakfast

Mid-morning snack

Lunch

Mid-afternoon snack

Dinner

Evening snack

Do you drink coffee / caffeinated beverages? How much and when?

Do you crave sweet, salty, sour, or spicy food?

Do you smoke, drink regularly (wine, beer), or use drugs? Do you live with someone who does?

Are you religious or do you have a regular spiritual practice?

Do you have a circle of support in friends or family members?

What are your favorite hobbies and recreational activities?

**Women's Section**

Pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ C-Sections \_\_\_\_\_ Children \_\_\_\_\_

Age of first period? \_\_\_\_\_ Date of last period (1<sup>st</sup> day) \_\_\_\_\_

Duration of flow \_\_\_\_\_ Flow color \_\_\_\_\_ Clots? \_\_\_\_\_ Cramps? \_\_\_\_\_

Other? \_\_\_\_\_

Menopause symptoms? \_\_\_\_\_

Contraception method \_\_\_\_\_ Date of last exam? \_\_\_\_\_

## **Past Medical History**

What is notable about the health of your mother, father, siblings, or grandparents?

Any past major injuries (fractures, dislocations, etc.) *with residual problems*?

Who have you seen for this and what have they done for it?

Any surgeries and/or hospitalizations? When and what for?

Circle what you have had: measles, mumps, chicken pox or other childhood diseases?

Do you have any known allergies? Are you allergic to any medications?

List *all* current medications, vitamins and herbs and who prescribed them:

Who is your primary healthcare provider?

## **Western Medicine Systems – Please Circle**

**Skin:** rashes, itching, lesions, bruising

**Head:** trauma, headache, tenderness

**Eyes:** vision, changes in visual field, sensitive to light, blurring, spots, discharge, inflammation

**Ears:** hearing changes, ringing, pain, discharge, vertigo

**Nose:** sinus problems, nosebleeds, obstruction, congestion, polyps, snoring

**Throat:** teeth, tongue, gums, dentures, lesions, hoarseness, sore throats

**Respiratory:** chest pain, chest tightness, sneezing, difficulty breathing, asthma, hay-fever, cough, phlegm (amount, color, consistency), coughing up blood, history of pneumonia

**Cardiovascular:** chest pain, difficulty breathing on exertion, murmurs, hypertension, leg cramps

**Gastro-intestinal:** low appetite, hard to swallow, nausea, vomiting, vomit blood, indigestion, abdominal pain, diarrhea, constipation, bloating, anal discomfort, hemorrhoids, change in stool shape and color

**Genito-urinary:** frequent, urgent, hesitant, pain, blood, incontinence, venereal disease, discharge, sterility, impotence

**Endocrine:** thyroid, adrenal, blood sugar / diabetes, hormones

**Hematology:** anemia, bleeding, easy bruising

**Neuropsychiatric:** fainting, seizures, weakness, coordination, sensations, memory, mood, sleep pattern, emotional disturbances, drug and alcohol problems