

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 your progress, 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 will put us into spam. 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 for all schedule changes made with less than 24-hour notice on the previous business day and any missed visits.
- 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 (1st 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