Center for Acupuncture – New Patient Information Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name		S	Sex M	F	Date	Email _	
Address		Cit	у		St	ate	Zip
Date of Birth	Place o	f birth		_ Age _	Height	Wei	ght
Telephone: Home ()	Work ()		Cell ()	
Single	Married	Divorced	Wide	owed	Living with	n	
Education			Occu	pation			
Referred by:							
Reason for visit today							
Other problems							
How long have you ha	ad this condition?		Hav	e you eve	er experienced	this before	?
What seemed to be th	ne initial cause? _						
What seems to make	it better?						
What seems to make	it worse?						
Does it bother your	SleepWork	_other (what?)					

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs)	Coffee/Tea (cup	ps)	Alcohol (drinks per week)	
Marijuana				
Other recreational drugs				
Vitamins & herbs				
Dietary restrictions				
Food cravings				
Diet: What might you eat on a typical	day?			
Breakfast				
Lunch				
Dinner				
Snacks				
Exercise		How often?		
What non-work activities do you enjo	y doing? (readin	ng, TV, meditation, mus	sic, etc.)	
MEDICINES: Prescription drugs you are currently t	taking: 	For what condition		
Over-the-counter medication you are	currently taking: 	: For what condition		

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS				
Date of last physical examination:					

Name & address of physician _____

Phone number of physician _____

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before?YesNo

GYNECOLOGY

Age of first menses:	Date of last menstrual period:	Duration of flow			
Blood clots: yesnowhen:	Length of cycle				
Color of menstrual blood:palebright	reddark redbrown other				
Texture of menstrual blood: thickthir	nwaterynormal				
Pain: yesnowhen:					
Irregular periods (describe):					
PMS (please describe):					
Current method of contraception:	Past method	of contraception:			
Are you currently pregnant?yesno					
Number of pregnancies:					
Number of live births:					
Number of miscarriages:					
Number of abortions:					
Any premature births:					
Breast (lumps, cysts, tenderness, et	c.):				
Urinary tract infections:	How frequent?				
Vaginal infections/ discharges (desc	ribe color):				
Pain/itching of genitalia:					
Pap smear:normalabnormalDate of last Pap smear:					
Uterine fibroids: Endometriosis: Other:					
Menopause (date of onset): Symptoms:					
Any bleeding since?					
Are you currently on Hormone Repla	acement Therapy (HRT)? yesnoDose:				
How long have you been on HRT?	Any side effects?				
Other:					

Please put a <u>"C"</u> if the condition is current or a <u>"P"</u> if you had it in the past

General

- __ Insomnia
- ___ Dreams/ nightmares
- Irritability
- Depression
- ___ Mood swings
- ___ Fatigue
- Poor memory
- ___ Strongly like cold drinks
- ___ Strongly like hot drinks
- ___ Recent weight loss/gain
- __ Cold hands & feet
- Chills
- Fever

Head & Neck

- ___ Headaches
- ___ Migraines
- _____ Stiff neck
- __ Dizziness
- ____ Fainting
- Swollen glands

Ears

- ___ Ringing
- ____ Hearing loss
- ___ Infections
- ___ Earache
- ___ Hearing aids
- ___ Vertigo

Eyes

- ____ Glasses/ contact lenses
- Blurred vision
- Poor night vision
- ____ Spots or floaters
- ___ Eye inflammation
- __ Double vision
- __ Glaucoma
- __ Cataracts

Nose, Throat & Mouth

- ____ Sinus infection
- ___ hay fever/ allergies
- ___ Frequent sore throat
- ____ difficulty swallowing
- ____ Mouth & tongue ulcers
- ___ Frequent colds
- ___Nosebleed
- __ Dry nose
- ___ Nasal congestion
- ___Loss of voice
- ___ Thirst
- Excessive phlegm
- ____TMJ
- ___Facial pain
- ___ Gum problems
- ___ Dry mouth

Skin

- ___ Hives
- ___Rashes
- ___ Eczema/ psoriasis
- ____Night sweating
- ___ Excess sweating
- ___ Dry skin
- ___ Easy bruising
- ___ Changes in moles, lumps

Musculoskeletal

____ Sore muscles

____Weak muscles

Difficulty walking

___ Upper back pain

___ Lower back pain

___Other (describe)

___ Rib pain

Neurological

___ Seizures

___ Tremors

__ Paralysis

__ Pain

___ Neck/shoulder pain

____ Limited range of motion

___ Numbness or tingling

___ Poor coordination

___ Pain on urination ___ Frequent urination

___ Unable to hold urine

___ Incomplete urination

Other (describe)

___ Urgent urination

___ Blood in urine

____Bedwetting

____ Wake to urinate

___ Increased libido

___ Decreased libido

___ Premature ejaculation

___ Nocturnal emission ___ Pain/itching of genitalia

Lumps in testicles

Infection Screening

____HIV risks: self or partner ____TB: self or household

___ Hepatitis risk: self or partner

disease: self or partner

___ History of sexually transmitted

___ Kidney stones

___ Impotence

___ Gonorrhea

___ Chlamydia

___ Genital warts

___ Herpes: oral/ genital

___ Syphilis

Other

Genito-urinary

Joint pain/disorder

___ Itching

Respiratory

- Difficulty breathing
- ___ Difficulty breathing when lying
- down
- ___ Wheezing
- Asthma
- ___ Chronic cough
- ____Wet cough
- ___ Dry cough
- ___ Coughing up phlegm
- ___ Coughing up blood
- ___ Shortness of breath
- ____ Tight chest
- ___ Pneumonia

Cardiovascular

- ___ High blood pressure
- ___Low blood pressure
- ___Chest pain or tightness
- ____ Palpitation
- ___Rapid heart beat
- __ Irregular heart beat
- Poor circulation
- _____ Swollen ankles
- ___ Phlebitis
- ___ Anemia
- ____ History of heart attack

Gastrointestinal

- ___Nausea
- Indigestion
- ___ Stomach pain
- __ Diarrhea
- ___ Constipation
- ____Poor appetite
- ___ Excessive hunger

___Acid regurgitation

___ Vomiting ___ Gas ___ Hiccups

___ Bloating

___Bad breath

___Laxative use

Bloody stool

Mucus in stool

___ Hemorrhoids Gall Bladder disorder