Name:	**SS#**	**Birthdate: / /**
	Marital Status:	**Age:**
Address:		**[] M [] F Ht. Wt.**
Home Phone:	**Work Phone:**	**Occupation:**
Emergency Contact - Name and Phone:		
Allergies (medication, food, etc.)		
Referred by/How did you hear about us?:		
Reason for visit today?	**Have you had acupuncture before? [] Yes [] No**	**Chinese herbal medicine? [] Yes [] No**
How long have you had this condition?		
Is it getting worse?	**Does it bother your: [] Sleep [] Work [] other What?**	
What seemed to be the initial cause?		
What seems to make it better?		
What seems to make it worse?		
Are you under the care of a physician now? []Yes [] No If yes, for what?		
Who is your physician?		**Phone:**
What treatments are you getting for this condition? (physical therapy, massage, yoga, aromotherapy, etc.)		
Current Medications:		

Family Medical History:

[] Heart disease	[] Diabetes	[] Cancer	[] High Blood Pressure
[] Stroke	[] Asthma	[] Seizures	[] Alcoholism
_____	_____	_____	_____

Your Past Medical History

[] AIDS/HIV	[] Diabetes	[] Multiple sclerosis	[] Thyroid
[] Alcoholism	[] Emphysema	[] Mumps	[] TB
[] Allergies	[] Epilepsy	[] Pacemaker	[] Typhoid fever
[] Appendicitis	[] Goiter	[] Pneumonia	[] Ulcers
[] Asthma	[] Heart Disease	[] Seizures	[] _____
[] Cancer	[] Hepatitis	[] Stroke	[] _____
[] Chicken Pox	[] High Blood Pressure	[] _____	[] _____

List any hospitalizations you have had during the past 5 years:_____

_____

Surgeries: (list) _____

_____

Your Diet

Appetite: [] Low [] Coffee [] Soft Drinks [] Sugar [] Artificial Sweetener
[] Normal [] Tea [] Salty Food [] Thirst for water: #glass/day _____
[] High

Average daily menu:

Morning_____ Snack _____

Snack _____ Evening_____

Noon _____ Snack _____

Your Lifestyle

[] Alcohol [] Marijuana [] Stress [] Tobacco [] Drugs [] Occupational Hazards

Regular Exercise: Type: _____ How Often _____

General Symptoms

[] Poor appetite	[] Poor sleep	[] Body feels heavy	[] Chills
[] Excess appetite	[] Sleep too much	[] Cold hands/feet	[] Night sweats
[] Strongly like cold drinks	[] Dream disturbed sleep	[] Poor circulation	[] Sweat easily
[] Strongly like hot drinks	[] Fatigue	[] Shortness of breath	[] Muscle cramps
[] Recent weight loss/gain	[] Lack of strength	[] Fever	[] Vertigo or dizziness
[] Bleed or bruise easily	[] Peculiar tastes (describe) _____		

Head, Eyes, Ears, Nose, Throat

[] Glasses	[] Night blindness	[] Sores on lips/tongue	[] Recurrent sore throat
[] Headaches	[] Glaucoma	[] Dry mouth	[] Swollen glands
[] Red eyes	[] Cataracts	[] Excessive saliva	[] Lumps in throat
[] Itchy eyes	[] Teeth problems	[] Sinus problems	[] Enlarged thyroid
[] Spots in eyes	[] Grinding teeth	[] Excessive phlegm	[] Nose bleeds
[] Poor vision	[] TMJ	Color of phlegm	[] Ringing in ears
[] Blurred vision	[] Facial pain	_____	[] Poor hearing
[] Dry eyes	[] Gum problems	Other: _____	

Respiratory

[] Difficulty breathing when lying down	[] Tight chest	[] Cough	Color of phlegm
	[] Asthma/wheezing	Wet or Dry? _____	_____
[] Shortness of breath	[] Pneumonia	Thick or Thin? _____	[] Cough blood

Cardiovascular

[] High blood pressure	[] Low blood pressure	[] Chest pain	[] Palpitations
[] Phlebitis	[] Blood clots	[] Fainting	[] Difficult breathing
[] Irregular heart beat	Are you taking blood thinners or aspirin? [] Yes [] No		

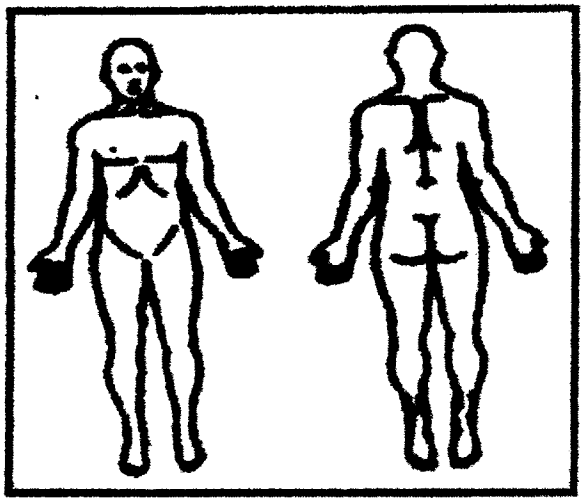
Gastrointestinal

[] Nausea	[] Diarrhea	[] Intestinal pain or cramping	Bowel Movements
[] Vomiting	[] Constipation	[] Itchy anus	Frequency _____
[] Acid regurgitation	[] Use laxatives	[] Burning anus	Color _____
[] Gas	[] Black stools	[] Rectal pain	Formed or loose _____
[] Hiccups	[] Bloody stools	[] Hemorrhoids	Strong odor: []Yes [] o
[] Bloating	[] Mucus in stools	[] Anal fissures	
[] Bad breath			

Musculoskeletal

[] Neck/Shoulder Pain	[] Upper back pain	[] Joint pain
[] Muscle pain	[] Low back pain	[] Rib pain
[] Limited range of movement	[] Sciatica	[] Paralysis
	[] Numbness	

Mark areas of pain on the diagram



Skin and Hair

[] Rashes [] Eczema [] Dandruff [] Change in hair/skin texture
[] Hives [] Psoriasis [] Itching [] Fungal infections
[] Ulcerations [] Acne [] Hair loss
Other hair or skin problems: _____

Neuropsychological

[] Seizures [] Poor memory [] Irritability [] Considered or attempted suicide
[] Depression [] Easily stressed [] Anxiety [] Seeing a therapist
[] Tics [] Abuse survivor
Other: _____

Genitourinary

[] Pain on urination [] Blood in urine [] Venereal disease [] Increased libido
[] Frequent urination [] Unable to hold urine [] Bedwetting [] Decreased libido
[] Urgent urination [] Incomplete urination [] Wake to urinate [] Impotence
[] Kidney stone [] Premature ejaculation
[] Testicular self exam

Gynecology

Age menses began _____ Duration of Flow _____ [] Vaginal discharge color _____ [] Breast lumps
Length of cycle _____ [] Irregular periods [] Vaginal sores [] # pregnancies _____
[] Date last period began _____ [] Painful periods [] Vaginal odors [] # live births _____
[] Clots [] Breast self exam [] # abortions _____
[] PMS Date of last PAP exam _____ [] # premature births _____
Age of menopause _____
Other: _____