



NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ E-MAIL _____

AGE _____ DATE OF BIRTH _____ PLACE OF BIRTH _____

EMPLOYER NAME AND ADDRESS _____

FAMILY PHYSICIAN _____ REFERRED BY _____

PREFERRED PHONE _____

EMERGENCY CONTACT _____ CONTACT'S PHONE _____

Have you been treated by Acupuncture or Chinese Medicine before? Yes No

Have you been treated by Manipulation before? Yes No

What is the main complaint that brings you here?: _____

How long have you noticed these symptoms? _____

To what extent do the symptoms affect your daily well-being? _____

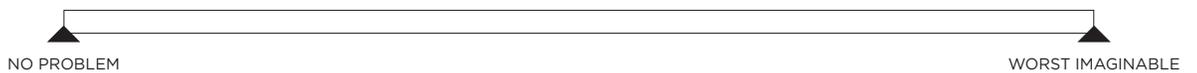
Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried? _____

Please note the severity of your problem now:



Please note the severity of your problem withing the last week:



Past medical history: (please include dates)

- Cancer _____ Heart Disease _____ Venereal Disease _____
- Diabetes _____ Rheumatic Fever _____ HIV/AIDS _____
- Hepatitis _____ Thyroid Disease _____ Other _____
- High Blood Pressure _____ Seizures _____

Surgeries (type and date) _____

Significant Trauma (auto accidents, falls, etc.) _____

Significant Dental Work (type and date) _____

Birth History (prolonged labor, forceps delivery, etc.) _____

Allergies (drugs, chemicals, food/results) _____

Family Medical History Diabetes Cancer High Blood Pressure Heart Disease

Stroke Seizures Asthma Allergies Other _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.) _____

Occupational Stress (physical, chemical psychological, etc.) _____

Do you have a regular exercise program? Yes No Please describe: _____

Are you on a restricted diet? Yes No What kind? _____

Please describe your average daily diet?

Morning: _____

Afternoon: _____

Evening: _____

How many cigarettes do you smoke per day? _____ How many cups coffee, tea, or cola do you drink per day? _____ How much alcohol do you drink a week? _____

Please describe any use of drugs for non-medical purposes _____

Please check any you have had in the last three months:

General

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Thirsts, no desire to drink | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Chills | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Tremors | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Strong thirst (cold or hot?) | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Weight loss |

Skin and Hair

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Other |
| <input type="checkbox"/> Change in hair or skin | <input type="checkbox"/> Hives | _____ |

Head, Eyes, Ears, Nose, and Throat

- Dizziness
- Glasses
- Poor vision
- Cataracts
- Ringing in ears
- Sinus problems
- Grinding teeth
- Concussions
- Eye strain
- Night blindness
- Blurry vision
- Poor hearing
- Nose bleeds
- Facial pain
- Jaw clicks
- Migraines
- Eye pain
- Color blindness
- Earaches
- Spots in front of eyes
- Recurrent sore throat
- Sores on lips or tongue
- Headaches when:
- Other _____

Cardiovascular

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Phlebitis
- Chest pain
- Fainting
- Swelling of feet
- Difficulty in breathing
- Other _____

Respiratory

- Cough
- Bronchitis
- Difficult breathing
- Production of phlegm
- Coughing blood
- Pneumonia
- Asthma
- Pain with deep breath
- Other _____

Gastrointestinal

- Nausea
- Constipation
- Black stools
- Bad breath
- Abdominal pain or cramps
- Chronic laxative use
- Vomiting
- Gas
- Blood in stools
- Rectal pain
- Diarrhea
- Belching
- Indigestion
- Hemorrhoids
- Other _____

Genitourinary

- Pain on urination
- Urgency to urinate
- Frequent urination
- Unable to hold urine
- Impotency
- Blood in urine
- Kidney stones
- Sores on genitals
- Other _____
- Do you wake up to urinate?
 Yes No
 How often? _____
 Any particular color to your urine? _____

Musculoskeletal

- Neck pain
- Back pain
- Hand/wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain
- Other _____

Neuro-psychological

- Seizures
- Areas of numbness
- Concussion
- Bad temper
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Other _____

Pregnancy and Gynecology

- Number of pregnancies _____
- Number of births _____
- Premature births _____
- Miscarriages _____
- Unusual character (heavy or light)
- Painful periods
- Vaginal discharge
- Changes in body/psyche prior to menstruation
- Abortions _____
- Age of first menses _____
- Days between menses _____
- Duration _____
- Clots
- Vaginal sores
- Irregular periods
- Last Pap _____
- Breast lumps
- Do you practice regular birth control?
 Yes No
- What type and for how long?
- Other _____