Ancient City Acupuncture & Herbal Medicine

Yvonne C. Towsley, AP, DOM, DACM

PATIENT INFORMATION

Date:____/_____/_____ Person Completing Form:_____

Legal Name: _____

Preferred name:_____

Place of Birth:_____

Date of Birth:____/_____/_____ Age:_____ Sex:_____

Weight:_____ Height:_____

Marital Status: Single - Married - Life Partner - Divorced - Widowed

Address:_____

City:_____ State:_____ Zip_____

Phone:_____ Mobile Phone:_____

E-mail Address:_____

Business

Address:_____

City:_____ State:_____ Zip_____

Occupation:_____

Current physicians, their specialties and numbers: (use additional page if more space is needed)

_____

_____

_____

_____

How did you hear of this office?

Have you ever before tried acupuncture or Chinese herbal medicine?

What are the main health problems for which you are seeking treatment?

Please rate the extent to which your current complaint affects your daily life
(1 = minor; 10 = major)

Please rate your commitment to resolving this problem (1 = minor; 10 = major)

What other forms of treatment have you sought?

MEDICATIONS

List all medications and/or supplements you are currently taking

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LIFESTYLE

- ☐ Alcohol
- ☐ Black tea
- ☐ Caffeinated Beverages
- ☐ Coffee
- ☐ Exercise
- ☐ Recreational Drugs
- ☐ Tobacco
- ☐ Other (please specify)

FAMILY MEDICAL HISTORY

(check all which apply and specify which blood relative)

- ☐ Accidents
- ☐ Allergies
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Childhood Illnesses
- ☐ Diabetes
- ☐ Emotional Disorder
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Medications
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Significant Trauma
- ☐ Surgeries
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vaccinations
- ☐ Other (please specify)

PAST MEDICAL HISTORY

- ☐ Accidents
- ☐ Allergies
- ☐ Birth Trauma
- ☐ Cancer
- ☐ Childhood Illnesses
- ☐ Diabetes
- ☐ Emotional Disorder
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Significant Trauma
- ☐ Surgeries
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vaccinations
- ☐ Other (please specify)

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Cough
- ☐ Dizziness
- ☐ Fainting
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Swelling of Hands/Feet
- ☐ Other (please specify)

GASTROINTESTINAL

- ☐ Abdominal Pain/Cramps
- ☐ Bad Breath
- ☐ Belching
- ☐ Black Stools
- ☐ Bloating
- ☐ Blood in Stool
- ☐ Chronic Laxative Use
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Appetite
- ☐ Gas
- ☐ Heartburn/Reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Lack of Appetite
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Retention of Food in Stomach
- ☐ Sensitive Abdomen
- ☐ Vomiting
- ☐ Other (please specify)

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GENITO-URINARY

- ☐ Blood in Urine
- ☐ Decrease in Urine Flow
- ☐ Frequent Urination
- ☐ Impotence
- ☐ Pain on Urination
- ☐ Unable to Hold Urine
- ☐ Urgency to Urinate
- ☐ Waking at Night to Urinate
- ☐ Other (please specify)

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dandruff
- ☐ Dry Mouth/Throat
- ☐ Eczema
- ☐ Eye Pain
- ☐ Facial Pain
- ☐ Floaters
- ☐ Hives
- ☐ Migraines
- ☐ Poor Hearing
- ☐ Spots in Eyes
- ☐ Toothaches
- ☐ Other (please specify)

MUSCULO-SKELETAL

- ☐ Areas of Numbness
- ☐ Back Pain
- ☐ Foot/Ankle Pain
- ☐ Hand/Wrist Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Sciatica
- ☐ Seizures
- ☐ Shoulder Pain
- ☐ Other (please specify)

NEURO-PSYCHOLOGICAL

- ☐ Anxiety
- ☐ Attempted Suicide
- ☐ Bad Temper
- ☐ Concussion
- ☐ Depression
- ☐ Dizziness
- ☐ Easily Stressed
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Poor Memory
- ☐ Treated for Emotional Problems
- ☐ Other (please specify)

REPRODUCTIVE/GYNECOLOGIC

- ☐ # Live Births
- ☐ # Miscarriages/Abortions
- ☐ # Pregnancies
- ☐ # Premature Births
- ☐ # days between periods
- ☐ # days of flow
- ☐ Age at menopause
- ☐ Age of 1st Period
- ☐ Breast Lumps/Swellings
- ☐ Clots (Color)
- ☐ Color of blood
- ☐ Decreased Sex Drive
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hot Flashes
- ☐ Irregular Menses
- ☐ Kidney Stones
- ☐ Ovarian Cysts
- ☐ Painful Menses
- ☐ Positive Mammogram/Pap Smear
- ☐ Premenstrual Symptoms
- ☐ Sexually Transmitted Disease
- ☐ Sores on Genitals
- ☐ Strong Menstrual Odor
- ☐ Urinary Tract Infection
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Vaginal Odor
- ☐ Other (please specify)

SKIN

- ☐ Hair Loss
- ☐ Pimples
- ☐ Psoriasis
- ☐ Recent Moles
- ☐ Redness
- ☐ Ulcerations
- ☐ Itching
- ☐ Other (please specify)