Confidential Case History

Asia America Acupuncture & Herb Institute

FULL NAME:	**SEX:**	**AGE:**
ADDRESS & ZIP:	**BIRTHDAY:**	
HOME PHONE:	**WEIGHT:**	**HEIGHT:**
CELL PHONE:	**MARITAL STATUS:**	
BUSINESS PHONE:	**PREGNANT:**	**LMP:**
EMAIL:	**OCCUPATION:**	
EMERGENCY CONTACT NAME, ADDRESS AND PHONE:	**DRIVER LICENSE:**	
	AUTO ACCIDENT ◯	
	WORKS COMP ◯	
	OTHER ◯	

WHY ARE YOU COMING TO MY OFFICE?

◯ **THIS IS A NEW ILLNESS**
◯ **THIS IS OLD ILLNESS**
◯ **IT WAS TREATED BEFORE**
◯ **IT NOT BEEN TREATED**

IF TREATED BEFORE, WHAT WAS DONE?

WHEN?
BY WHOM?

HAVE YOU HAD ACUPUNCTURE BEFORE, WHAT WAS DONE? ◯**YES** ◯**NO**
WHEN?
BY WHOM?

HAVE YOU HAD PROBLEMS WITH THERE? CKECK.

◯**LUMP**	◯**MOLES**
◯**STIFF JOINT**	◯**SWELLING**
◯**DIZZINESS**	◯**BALANCE**
◯**APPETITE**	◯**SLEEPING**
◯**BREATHING**	◯**PAIN, ACHES**
◯**HEARING**	◯**SEEING**
◯**SMELLING**	◯**RACING HEART**
◯**DIGESTION**	◯**WEIGHT**
◯**CONSTIPATION**	◯**DIARRHEA**
◯**MOOD OR FEELING**	◯**MENSTRUATION**
◯**TIREDNESS**	

LAST MEDICAL EXAMINATION:

WHO IS OR WAS YOUR REGULAR DOCTOR?
NAME:
CITY AND STATE:

CHCCK IF YOU OR YOUR RELATIVE HAVE HAD OR HAVE ANY OF THERE:

	YOU	**RELATIVE**
ANEMIA	◯	◯
ASTHMA	◯	◯
BLEEDING TENDENCIES	◯	◯
CANCER OR TUMOR	◯	◯
DIABETES	◯	◯
EPILEPSY	◯	◯
GLAUCOMA	◯	◯
GOUT	◯	◯
HEART TROUBLE	◯	◯
HIGH BLOOD PRESSURE	◯	◯
KIDNEY OR BLADDER TROUBLE	◯	◯
MENTAL DISORDER	◯	◯
RHEUMATISM OR ARTHRITIS	◯	◯
STROKE	◯	◯
TUBERCULOSIS	◯	◯
ULCER OR STOMACH TROUBLE	◯	◯
NUMBNESS	◯	◯
SCIATICA	◯	◯
SCOLIOSIS	◯	◯

ARE YOU TAKE ANY MEDICATION? **LIST BELOW:** **1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.** **ARE YOU TAKE ANY HERBS OR SUPPLEMENTS?** **LIST BELOW:** **1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9** **10.**	**HOW ARE YOUR DIETARY AND NUTRITIONAL HABIT?** **DO YOU EXERCISE REGULARLY? EXPLAIN.** **HAVE YOU EVER HAD SURGERY, OR BEEN HOSPITALIZED? (DO NOT COUNT NORMAL BIRTHS)** **IF YES, LIST BELOW:** **WHEN?** **WHERE?** **WHAT WAS WRONG?**
ARE YOU HAVING SORE THROAT, FEVER, OR SHORTNESS OF BREATH NOW?	
HAVE YOU HAD CLOSE CONTACT WITH Covid-19 PATIENT RECENT 14 DAYS?	

PATIENT'S NAME: (print) _____

PATIENT'S SIGNATURE: _____

TODAY'S DATE: _____