CONFIDENTIAL PATIENT INFORMATION

Name:____________________ Birth Date:____________ Age: ________

Sex: _____ Marital Status: ________________ [redacted]

Address: ____________________ City: ____________ State:______ Zip:______

Telephone: (day) (_____) ________________ (evening) (_____) ________________

Referred by: ____

Occupation: ____________________ Business/Employer: ____________________

Your Doctor's Name: ____________________ Specialty: ____________________

Insurance Company: ________________ Group No.: ____________ I.D. No.: ____________

Address: ______________________________ Telephone: (_____) ____________

MAJOR COMPLAINTS

Major Complaint: ____

When did this condition begin? __________________________________

What seemed to be the initial cause? ______________________________

Diagnosis by your doctor: __________________________________

To what extent does this problem interfere with your daily activities? ________________

____

What kinds of treatment have you tried? ____________________________

Medications you now take: __________________________________

Herbs/Vitamins: ____

MEDICAL HISTORY

Major Illnesses: ____

Surgery: ____

Significant Accidents: ____________________________________

Have you been treated for any health condition in the past year? __________________

____

Have you been treated by acupuncture before? __________________________

Check any illnesses which you now have or have had:

____ Allergies	____ Cancer	____ Hepatitis	____ Skin Disease
____ Anemia	____ Diabetes	____ High Blood Pressure	____ Thyroid Disease
____ Arthritis	____ Epilepsy	____ Kidney Disease	____ Ulcers
____ Asthma	____ Eye Disease	____ Liver Disease	Others: __________
____ Bronchitis	____ Heart Disease/Stroke	____ Lung Disease	________________

SYMPTOM SURVEY

GENERAL:
____ fatigue
____ insomnia
____ weight loss
____ weight gain
____ allergies

NERVOUS SYSTEM
____ headache
____ migraine
____ dizziness
____ tremors
____ numbness/tingling
____ imbalance
____ memory loss
____ muscle weakness

HEART/LUNG:
____ chest pain
____ high blood pressure
____ arteriosclerosis
____ shortness of breath
____ irregular heartbeat
____ varicose veins
____ ankle swelling
____ persistent cough

EMOTIONAL:
____ anxiety or worry
____ frequent crying
____ anger
____ tension
____ mood swings
____ fear
____ confusion
____ depression
____ suicidal

MUSCULOSKELETAL:
____ jaw pain
____ neck pain
____ shoulder pain
____ elbow pain
____ hand pain/stiffness
____ upper back pain
____ mid back pain
____ low back pain
____ hip pain
____ pain down leg
____ knee pain
____ ankle/foot pain
____ joint swelling
____ muscle cramps

ENT:
____ ear infections
____ ringing in ears
____ hearing loss
____ problem swallowing
____ dental problems
____ sinus problems

GENITOURINARY:
____ painful intercourse
____ prostate problems
____ sexual problems
____ loss of sex drive
____ genital infections
____ painful urination
____ frequent urination
____ hard to urinate
____ incontinence
____ bladder infections

SKIN:
____ easy bruising
____ dry skin
____ itching
____ rashes
____ hives

GYN:
____ irregular periods
____ cramps
____ PMS
____ heavy menstrual flow
pregnant? ___ yes ___ no
date last period ________
# of pregnancies _____
# of miscarriages _____
# of abortions ________
date last PAP ________
birth control method ____
____ breast problems
____ menopause

GASTROINTESTINAL:
____ change in appetite
____ heartburn
____ nausea/vomiting
____ diarrhea
____ constipation
____ gas
____ abdominal pain
____ indigestion
____ gall bladder problem
____ hemorrhoids

HABITS

	None	Moderate	Heavy
Alcohol	____	____	____
Tobacco	____	____	____
Exercise	____	____	____
Salty Foods	____	____	____
Artificial Sweeteners	____	____	____

	None	Moderate	Heavy
Coffee	____	____	____
Drugs	____	____	____
Soft Drinks	____	____	____
Sweets	____	____	____