Personal Information:

– Your details

Full Name * required

Email * required

Home Phone * required

Alternate Phone

Street

City

Zip code

Country

Place of Birth

Date of Birth

Your Height

Your Weight

Marital Status

Family Physician

In Emergency Notify

Emergency Phone

– Your details

Referred By

Insurance Company

Policy Number

Have you been treated by acupuncture or Oriental medicine before? ☐ yes ☐ no

– Current Health Problems

What are the main problem(s) you would like us to help you with?

How long ago did this problem begin (be specific)?

To what extent does this problem interfere with your daily activities (work, sleep, sex)?

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

What kinds of treatment have you tried?

Medical History:

Past medical history

Past medical history (please include date):

Significant Illnesses

☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ High Blood Pressure ☐ Heart Disease ☐ Rheumatic Fever ☐ Thyroid Disease ☐ Seizures ☐ Venereal Disease ☐ Other If Other, please explain

surgeries

significant trauma (auto accidents, falls, etc.)

birth history (prolonged labor, forceps delivery, etc.)

allergies

– **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.)

occupation

occupational stress (chemical, physical, psychological, etc.)

– **Do you have a regular exercise program?**

○ yes ○ no

Please describe?

– **Have you ever been on a restricted diet?**

○ yes ○ no

What Kind?

Please Describe your average daily diet in the morning?

Please Describe your average daily diet in the afternoon?

Please Describe your average daily diet in the evening?

How many packs of cigarettes do you smoke a day?

How much coffee, tea or cola do you drink per week?

How much alcohol do you drink per week?

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

Please check if you have had (in the last 3 months):

General

☐ Poor Appetite ☐ Fevers ☐ Sweat Easily ☐ Localized weakness ☐ Bleed or bruise easily ☐ Peculiar Taste or smells ☐ Strong thirst (cold or hot drinks) ☐ Poor sleeping ☐ Chills ☐ Tremors ☐ Poor Balance ☐ Weight Loss ☐ Fatigue ☐ Night Sweats ☐ Cravings ☐ Change in appetite ☐ Weight Gain ☐ Sudden energy drop

What time of day does your energy drop?

Skin And Hair

☐ Rashes ☐ Itching ☐ Dandruff ☐ Change in hair or skin texture ☐ Ulcerations ☐ Eczema ☐ Loss of Hair ☐ Hives ☐ Pimples ☐ Recent moles

Any other hair or skin problems?

Head, Eyes, Ears, Nose And Throat

☐ Dizziness ☐ Glasses ☐ Poor Vision ☐ Cataracts ☐ Ringing in ears ☐ Sinus Problems ☐ Grinding teeth ☐ Teeth problems ☐ 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 the eyes ☐ Recurrent sore throats ☐ Sores on lips or tongue

Headaches (where and when)?:

Any other head or neck problems

– Cardiovascular

☐ High Blood Pressure ☐ Irregular Heartbeat ☐ Cold Hands or Feet ☐ Blood Clots ☐ Low Blood Pressure ☐ Diziness ☐ Swelling of hands ☐ Phlebitis ☐ Chest pain ☐ Fainting ☐ Swelling of Feet ☐ Difficulty in breathing

Any other heart or blood vessel problems?

– Respiratory

☐ cough ☐ bronchitis ☐ difficulty in breathing when lying down ☐ coughing blood ☐ pneumonia ☐ Asthma ☐ pain with a deep breath ☐ Production of phlegm

If phlegm, what color?

Any other lung problems?

– Gastrointestinal

☐ nausea ☐ constipation ☐ black stools ☐ bad breath ☐ abdominal pain or cramps ☐ chronic laxative use ☐ vomitting ☐ gas ☐ blood in stools ☐ rectal pain ☐ diarrhea ☐ belching ☐ indigestion ☐ hemorrhoids

Any other problems with your stomach or intestines?