Center for Acupuncture – New Patient Information Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name	Sex M F Date Email
AddressC	City State Zip
Date of BirthPlace of birth	Age Height Weight
Telephone: Home () Work	Cell ()
SingleMarriedDivorced	Widowed Living with
Education	Occupation
Referred by:	
Reason for visit today	
Other problems	
How long have you had this condition?	Have you ever experienced this before?
What seemed to be the initial cause?	
What seems to make it better?	
What seems to make it worse?	
Does it bother your SleepWorkother (what	?)

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
age of death						
hepatitis						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)			
Cigarettes (packs) _	Coffee/Tea (c	eups) Alco	hol (drinks per week)
Marijuana			
Other recreational di	ugs		
Vitamins & herbs			
Dietary restrictions _			
Food cravings			
Diet: What might you	u eat on a typical day?		
Breakfast			
Lunch			
Dinner			
Snacks			
Exercise		How often?	
What non-work activ	ities do you enjoy doing? (read	ing, TV, meditation, music, e	tc.)
MEDICINES: Prescription drugs ye		For what condition?	
Over-the-counter me	edication you are currently takin	g: For what condition?	
	ZATIONS If you have ever bee below: (do not include normal p		us medical illness or operation, write
YEAR	OPERATION/ ILLNESS		
Date of last physical	examination:		
Name & address of p	ohysician		
Phone number of ph	ysician		

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before?YesNo

GYNECOLOGY

Age of first menses:	Date of last menstrual period:	Duration of flow
Blood clots: yesnowhen:	Length of cycle	1
Color of menstrual blood:palebri	ght reddark redbrown other	
Texture of menstrual blood: thick	thinwaterynormal	
Pain: yesnowhen:		
Irregular periods (describe):		
PMS (please describe):		
Current method of contraception	: Past r	method of contraception:
Are you currently pregnant?yesn	10	
Number of pregnancies:		
Number of live births:		
Number of miscarriages:		
Number of abortions:		
Any premature births:		
Breast (lumps, cysts, tenderness	s, etc.):	
Urinary tract infections:	How frequent?	
Vaginal infections/ discharges (d	escribe color):	
Pain/itching of genitalia:		
Pap smear:normalabnormalDate	e of last Pap smear:	
Uterine fibroids:	Endometriosis:	Other:
Menopause (date of onset):	Symptoms:	
Are you currently on Hormone R	eplacement Therapy (HRT)? yesnoDo	ose:
How long have you been on HR	Γ? Any side effe	cts?
Other:		

Hives Preams/ nightmares Hives Preams/ nightmares Rashes Eczema/ psoriasis Weak muscles Weak nuscles Weak nu	General	Skin	Musculoskeletal
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Irritability Depression Night sweating Depression Depression Depression Night sweating Depression D			
Depression Night sweating Difficulty walking Neckshoulder pain Lower back		Eczema/ psoriasis	Weak muscles
Mood swings Fatigue Poor memory Strongly like cold drinks Easy bruising Changes in moles, lumps Lower back pain Lower back			
Fatigue Poor memory Strongly like cold drinks Strongly like hot drinks Recent weight loss/gain Cold hands & feet Chillian Strongly like hot drinks Recent weight loss/gain Cold hands & feet Chillian Strongly like hot drinks Recent weight loss/gain Cold hands & feet Chillian Strongly like hot drinks Recent weight loss/gain Cold hands & feet Chillian Strongly like hot drinks Recent weight loss/gain Cold hands & feet Chillian Strongly like hot drinks Recent weight loss/gain Cold hands & feet Chillian Strongly Respiratory Respiratory Chillian Strongly Respiratory			<u> </u>
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Stiff neck Dizziness Dry cough Dizziness Painting Swollen glands Ears Ringing Hearing loss Infections Earache Hearing aids Vertigo Vertigo Eyes Glasses/ contact lenses Blurred vision Poor right vision Spots or floaters Eye inflammation Double vision Glaucoma Cataracts Glaucoma Cataracts Castrointestinal Double vision Glaucoma Cataracts Gastrointestinal Double vision Glaucoma Cataracts Frequent olds Nose, Throat & Mouth Sinus infection Any fever/ allergies Frequent sore throat difficulty swallowing Mouth & tongue ulcers Frequent colds Dry coughing up phlegm Coughing up blood Genito-urinary Pain on urination Frequent urination Urgent urination Bloode pressure Unable to hold urine Incomplete urination Bloode pressure Unable to hold urine Incomplete urination Bedwetting Wake to urinate Increased libido Decreased libido Nictinate Increased libido Ridney stones Impotence Frequent cejaculation Nake to urinate Increased libido Ridney stones Impotence Premature ejaculation Nocturnal emission Paint/tching of genitalia Lumps in testicles Infection Screening HIV risks: self or partner History of sexually transmitted disease: self or partner History of sexually transmitted disease: self or partner History of sexually transmitted disease: self or partner Genorrhea Chlamydia Syphilis Syphilis Syphilis Syphilis Syphilis Frequent urination Urgent urination Frequent urination Urgent urination Urgent urination Prequent urination Urgent urination Frequent urination History of in trine Unable to hold urine Incomplete urination Frequent urination Frequent urination Frequent urination Urgent urination Frequent urination History of in trine Unable to hold urine Incomplete urination Frequent urination Frequent urination Frequent urination Incomplete urination Frequent urination Incomplete urination Frequent urination Incomplete urination Frequen			
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