# Acuremedy - Acupuncture and Chinese Herbal Medicine
## In Take form

 Date:

Please fill out this questionnaire to the best of your ability. All of your answers will be held confidential. Please add details when relevant. Thank you. (How do you find us? ❑ friends ❑ website ❑ others

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|---|---|---|
| Name (Last, First Name): | Home phone: | Work phone: |
| Address: #, Street | City | State/Zip |
| Date of Birth: | Age | Email Address: |
| Occupation: | Physician (name, phone #): | Height/Weight: |
| Emergency Contact (name): (phone #): | | Relation to you: |
| Are you a member of Blue Cross? ( Y or N ) | | Referred by: |

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| Have you been treated by acupuncture or Oriental Medicine before? ( Y or N) |
| Main problems(s) you would like us to help you with? |
| How long ago did this problem begin? Please be specific.<br>Length of time:<br>Severity: |
| To what extent does this problem interfere with your daily activities, such as work, sleep, & sex? |
| Secondary or other problems: |
| What other kinds of treatment have you tried? |

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| Past medical history? (circle all applicable)<br>Cancer diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever<br><br>Thyroid Disease Seizures Venereal Disease HIV AIDs TB Hep A/B/C Other (please specify): |
| Surgeries (what? Date?): |
| Significant trauma (what? Date?): |
| Significant illness (what? Date?): |
| Allergies (drugs, chemicals, foods): |
| Family Medical History: (circle all applicable)<br>Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures Asthma<br><br>Allergies Others |
| Medicines taken within the last two months (vitamins, drugs, herbs, etc.) |
| Occupational stress (chemical, physical, psychological, etc.) |

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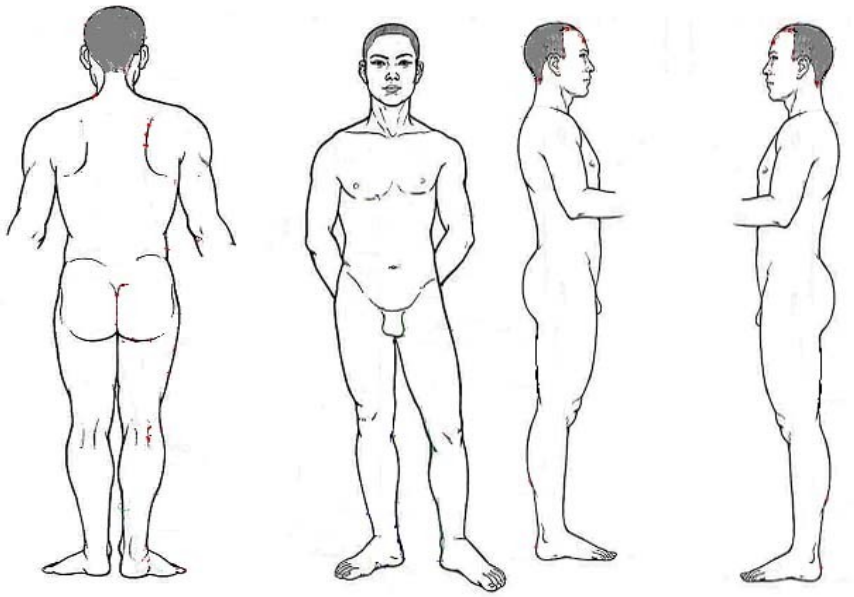
| Do you have a regular exercise program? If yes, please describe. |
| Have you been on restricted diet? If yes, what kind? |
| Please describe your average daily diet:<br>Morning: Noon: Evening:<br>_____<br>_____ |
| Do you smoke? If yes, how much (# or packs)? |
| How much caffeinated coffee, tea, or cola do you drink (# of cups daily)? |
| Recreational Drugs? ( Y or N ) Alcohol use (# of drinks daily): |
| How much water do you drink per day? How much alcohol do you drink? |
| Please describe any use of drugs for non-medical purposes. |

Indicate where the focal areas are:



**Indicate in the box with an "X" if you suffer from:**

- ❑ Vision Problems 視力
- ❑ Hearing Problems 聽 力
- ❑ Nasal/Skin Allergies 鼻/皮膚過敏
- ❑ Bronchitis 支氣管炎
- ❑ Excessive Colds 易外感
- ❑ Sinus 鼻竇炎
- ❑ Bad Breath 口臭
- ❑ Heartburn 胃脘灼熱感
- ❑ Stomach Pains 胃脘痛
- ❑ Gas 噯氣
- ❑ Appetite-Big-Small 食慾亢進/減退
- ❑ Diarrhea 腹瀉
- ❑ Constipation 便秘
- ❑ Inflamed Gums 齒?炎
- ❑ Liver 肝
- ❑ Gall Bladder 膽囊
- ❑ Appendicitis 闌尾
- ❑ Circulation 血循環
- ❑ Heart 心臟
- ❑ Varicose Veins 靜脈曲張
- ❑ Memory 記憶力
- ❑ Cholesterol 膽固醇
- ❑ Nerves 精神緊張
- ❑ Depression 抑鬱
- ❑ Anxiety 憂慮
- ❑ Fatigue 疲乏
- ❑ Migrains 偏頭痛
- ❑ Headaches 頭痛
- ❑ Kidneys 腎
- ❑ Excessive Urine 尿頻`多
- ❑ Problems with urinating 尿問題
- ❑ Rheumatism 風濕
- ❑ Arthritis 關節炎
- ❑ Legs & arms pain 下/上肢痛
- ❑ Muscular Tension 肌肉緊張
- ❑ Backache 腰背痛
- ❑ Bone Pain 骨痛
- ❑ Insomnia 失眠
- ❑ Diabetes 糖尿病
- ❑ Anemia 貧血
- ❑ Asthma 孝喘
- ❑ Alcoholism/Smoke/Drugs 嗜酒/煙/毒
- ❑ Prostate/Ovaries 前列腺/軟巢
- ❑ Vaginal Infections 陰道炎
- ❑ Menstrual Problems 月經問題
- ❑ Pregnancy 妊娠
- ❑ Impotent 陽萎
- ❑ Frigidity 低性感
- ❑ Menopause 更年期
- ❑ Parasites 寄生蟲
- ❑ Hign/Low Blood Pressure 高/低血壓
- ❑ Skin Problems: Eczema/Psoriasis/Acne/Dry/Greasy 皮膚病
- ❑ Hair Problems: Falls out excessively/Very Dry/Greasy/Dandruff/Saborrhea 毛髮問題