

# PATIENT INFORMATION

## PATIENT INFORMATION

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Significant Other  
 Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Emp. Address \_\_\_\_\_

Emp. Phone \_\_\_\_\_

Spouse/Partner's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse/Partner's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PHONE NUMBERS

H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_

Best time & place to reach you \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

## GENERAL INFORMATION

Have you had acupuncture before?  Yes  No Have you used Chinese herbal medicine?  Yes  No

Are you currently under the care of a physician?  Yes  No If Yes, for what? \_\_\_\_\_

Physician's name: \_\_\_\_\_

Physician's phone: \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to

\_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

# ORIENTAL MEDICINE INTAKE FORM

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PRESENT HEALTH CONCERNS:** Please list your most important health concerns in order of their significance.

1. \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Other therapies tried:  Medications  Surgery  Chiropractic  Phys. Therapy  Other \_\_\_\_\_

2. \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Other therapies tried:  Medications  Surgery  Chiropractic  Phys. Therapy  Other \_\_\_\_\_

3. \_\_\_\_\_ Approx. Date of Onset: \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Other therapies tried:  Medications  Surgery  Chiropractic  Phys. Therapy  Other \_\_\_\_\_

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

Please list any **vitamins, minerals, herbs, or homeopathic remedies** that you are presently taking:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

Please list **allergies** that you have to any of the following:

Drugs: \_\_\_\_\_ Foods: \_\_\_\_\_

Other (i.e. pollen, paint, etc.): \_\_\_\_\_

**HEALTH HISTORY**

**Past Medical History:** Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Personal Habits:**

Tobacco packs/day \_\_\_\_\_

Alcohol drinks/wk \_\_\_\_\_

Coffee/tea/cola cups/day \_\_\_\_\_

Recreational drugs times/wk \_\_\_\_\_

High Stress Level Reason \_\_\_\_\_

Do you follow any diet regimens/restrictions?

Yes  No

If Yes, describe: \_\_\_\_\_

**Work Activity:**

Sitting % of time \_\_\_\_\_

Standing % of time \_\_\_\_\_

Light labor % of time \_\_\_\_\_

Heavy labor % of time \_\_\_\_\_

**Exercise:**

Do you exercise regularly?  Yes  No

If Yes, describe & tell how

often: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY INFORMATION**

Do you have children?  Yes  No If Yes, how many? \_\_\_\_\_ Ages \_\_\_\_\_

Are you, or could you be currently pregnant?  Yes  No Due date \_\_\_\_\_

Please check if you have had (in the **last three months**)

#### GENERAL

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Poor appetite       | <input type="checkbox"/> Fevers/Chills         | <input type="checkbox"/> Tremors               |
| <input type="checkbox"/> Heavy appetite      | <input type="checkbox"/> Sweat easily          | <input type="checkbox"/> Poor sleeping         |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Localized weakness    | <input type="checkbox"/> Heavy sleeping        |
| <input type="checkbox"/> Weight loss/gain    | <input type="checkbox"/> Bleed / bruise easily | <input type="checkbox"/> Dream disturbed sleep |
| <input type="checkbox"/> Cravings            | <input type="checkbox"/> Sudden energy drop    | <input type="checkbox"/> Night sweats          |
| <input type="checkbox"/> Peculiar tastes     | (time?)  | <input type="checkbox"/> Dizziness             |
| <input type="checkbox"/> Strong thirst       | <input type="checkbox"/> Fatigue               |  |

#### SKIN AND HAIR

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes/Hives | <input type="checkbox"/> Ulcerations      | <input type="checkbox"/> Fungal infections              |
| <input type="checkbox"/> Itching      | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Recent moles                   |
| <input type="checkbox"/> Dry skin     | <input type="checkbox"/> Loss of hair     | <input type="checkbox"/> Change in hair or skin texture |
| <input type="checkbox"/> Dandruff     | <input type="checkbox"/> Pimples/Acne     |   |

Other hair or skin concerns:

#### HEAD, EYES, EARS, NOSE, AND THROAT

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Concussions                                      | <input type="checkbox"/> Spots in front of eyes        | <input type="checkbox"/> Swollen glands       |
| <input type="checkbox"/> Glasses/Contacts                                 | <input type="checkbox"/> Earaches/Infections           | <input type="checkbox"/> Sores on lips/tongue |
| <input type="checkbox"/> Eye strain/pain                                  | <input type="checkbox"/> Ringing in ears               | <input type="checkbox"/> Dry mouth            |
| <input type="checkbox"/> Red eyes   | <input type="checkbox"/> Poor hearing                  | <input type="checkbox"/> Excessive saliva     |
| <input type="checkbox"/> Itchy eyes                                       | <input type="checkbox"/> Sinus problems                | <input type="checkbox"/> Teeth problems       |
| <input type="checkbox"/> Dry eyes   | <input type="checkbox"/> Post nasal drip               | <input type="checkbox"/> Gum problems         |
| <input type="checkbox"/> Excessive tearing                                | <input type="checkbox"/> Excessive phlegm – color_____ | <input type="checkbox"/> TMJ disorder         |
| <input type="checkbox"/> Poor/blurry vision                               | <input type="checkbox"/> Nose bleeds                   | <input type="checkbox"/> Grinding teeth       |
| <input type="checkbox"/> Night blindness                                  | <input type="checkbox"/> Recurrent sore throats        |   |
| <input type="checkbox"/> Cataracts/Glaucoma                               |  |   |
| <input type="checkbox"/> <b>Headaches</b> (location, triggers, severity)? |  |   |

Other head & neck concerns:

#### CARDIOVASCULAR

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations      | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Blood clots      |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Cold hands/feet   | <input type="checkbox"/> Phlebitis        |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands |   |

Other heart or blood vessel concerns:

#### RESPIRATORY

- |   |   |
|---|---|
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Pain with deep breath                        |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Shortness of breath                          |
| <input type="checkbox"/> Wheezing       | <input type="checkbox"/> Tight chest                                  |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Production of phlegm - color? _____          |
| <input type="checkbox"/> Bronchitis     | Is it <input type="checkbox"/> thick or <input type="checkbox"/> thin |
| <input type="checkbox"/> Pneumonia      |   |

Other lung related concerns:



## GASTROINTESTINAL

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Belching           | <input type="checkbox"/> Abdominal pain       |
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Bad breath         | <input type="checkbox"/> Itchy anus           |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Blood in stools    | <input type="checkbox"/> Burning anus         |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Black stools       | <input type="checkbox"/> Hemorrhoids/fissures |
| <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Mucus in stools    |   |
| <input type="checkbox"/> Hiccups      | <input type="checkbox"/> Acid Regurgitation |   |

History of chronic laxative use?

Other concerns with your general digestion:

## GENTIO-URINARY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain on urination    | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Premature ejaculation             |
| <input type="checkbox"/> Frequent urination   | <input type="checkbox"/> Kidney stones    | <input type="checkbox"/> Nocturnal emissions               |
| <input type="checkbox"/> Blood in urine       | <input type="checkbox"/> Impotency        | <input type="checkbox"/> Sores on genitals                 |
| <input type="checkbox"/> Urgency to urinate   | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Chronic yeast infection           |
| <input type="checkbox"/> Decrease in flow     |   |  |

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

## MUSCULOSKELETAL

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Muscle weakness              | <input type="checkbox"/> Knee pain                               |
| <input type="checkbox"/> Upper back pain  | <input type="checkbox"/> Cramps/spasms                | <input type="checkbox"/> Foot/ankle pain                         |
| <input type="checkbox"/> Lower back pain  | <input type="checkbox"/> General joint pain/stiffness | <input type="checkbox"/> Hip pain                                |
| <input type="checkbox"/> Hand/wrist pains | <input type="checkbox"/> Shoulder pain                | <input type="checkbox"/> Joint with limited range of motion_____ |
| <input type="checkbox"/> Muscle pains     |   |  |

Other muscle, joint or bone concerns:

## NEUROPSYCHOLOGICAL

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Memory loss  | <input type="checkbox"/> Easily susceptible to stress        |
| <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Concussion   | <input type="checkbox"/> History of emotional/physical abuse |
| <input type="checkbox"/> Areas of numbness    | <input type="checkbox"/> Depression   |  |
| <input type="checkbox"/> Tics                 | <input type="checkbox"/> Anxiety      |  |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Irritability |  |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

## GYNECOLOGY

Age of first menses\_\_\_\_\_ If no longer menstruating, approximate date ceased\_\_\_\_\_

First day of last menses\_\_\_\_\_ Length between menses:\_\_\_\_\_days Duration of period:\_\_\_\_\_days

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Unusual flow ( <input type="checkbox"/> heavy or <input type="checkbox"/> light) | <input type="checkbox"/> Clots in flow                  | <input type="checkbox"/> Vaginal dryness       |
| <input type="checkbox"/> Painful periods  | <input type="checkbox"/> Vaginal discharge – color_____ | <input type="checkbox"/> Vaginal sores         |
| <input type="checkbox"/> Irregular periods  | <input type="checkbox"/> Vaginal odor                   | <input type="checkbox"/> Hot flashes           |
|   |   | <input type="checkbox"/> Breast lumps/soreness |

**GYNECOLOGY (continued)**

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP: \_\_\_\_\_ Results were:        normal    abnormal    unsure  
If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation?  
(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

**PREGNANCY HISTORY**

Number of pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_  
Were your births relatively normal? Explain:

Other related concerns:

**COMMENTS**

Please let us know of any other concerns you would like to address:

**Family History:** Please fill in the boxes for each condition that applies to one of your family members.

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

Signature: \_\_\_\_\_

Date: \_\_\_\_\_