



AcupunctChi Clinic

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Patient Information Form

To our new patients: Welcome to the AcupunctChi Clinic. Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in your evaluation and treatment.

All information is strictly confidential!

Personal History

Date: _____

Name: _____ Date of Birth ___/___/___ Age ___ Address: _____

Occupation _____ Birthplace _____

Date of Last Examination _____ Your Doctor's name: _____

Home Phone _____ Work phone _____ E-mail _____

Referred by: _____

Have you ever had acupuncture? _____ **If yes, when?** _____
For what condition(s)? _____

Allergies: _____

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

How long have you experienced symptoms? _____
Your condition is improved by? _____

Your condition is aggravated by? _____

Additional problems or concerns you would like addressed:

*Note: we may not be able to address every problem during the course of one visit.

Current Medications :	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
Current Herbs / Vitamins/ Supplements :	Dose	Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

Patient Name: _____

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: _____

Date: _____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

SOCIAL HISTORY (check those that apply): Patient Name: _____

Marital status:	Education level completed:	Memories of your childhood	Do You Find Your
Life			
<input type="checkbox"/> single	<input type="checkbox"/> high school	<input type="checkbox"/> Mostly happy	<input type="checkbox"/> Generally
Unsatisfactory			
<input type="checkbox"/> married	<input type="checkbox"/> college	<input type="checkbox"/> Mostly painful	<input type="checkbox"/> Too Demanding
<input type="checkbox"/> divorced	<input type="checkbox"/> professional school	<input type="checkbox"/> Normal	<input type="checkbox"/> Boring
<input type="checkbox"/> Widowed	<input type="checkbox"/> other: _____	<input type="checkbox"/> don't recall	<input type="checkbox"/> Satisfactory
Living arrangement:			
<input type="checkbox"/> alone <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> significant other			
<input type="checkbox"/> children (list sex/ages): _____			
<input type="checkbox"/> Major stresses in last 6 months <input type="checkbox"/> Money <input type="checkbox"/> Job <input type="checkbox"/> Marriage <input type="checkbox"/> HomeLife <input type="checkbox"/> Children			
<input type="checkbox"/> other stressors _____			

Pertinent travel history:(out of USA, epidemic areas)

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how many? # _____ yrs. _____ packs per day
Did you ever smoke?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when did you quit? _____
Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, how much? Type _____ & _____ drinks per week
Do you drink caffeinated beverages?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, which? _____
Do you use recreational drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, which? _____
Do you manage stress well?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	<input type="checkbox"/> NEED HELP
Do you exercise regularly?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you enjoy your job?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you allow time to unwind and relax?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Do you sleep soundly?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your sex life?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your social life?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Are you satisfied with your spiritual life?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If no, why? _____
Is your diet healthy enough?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	<input type="checkbox"/> NEED HELP

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____

Devices

Do You Use:

___ Eyeglasses	___ Contact Lens	___ Hearing Aid	___ Dentures
___ Brace (Neck, Back)	___ Pacemaker	___ IUD, Diaphragm	___ Artificial Limbs

REVIEW OF SYSTEMS

Patient Name: _____

Check any symptoms that currently apply to you:

General symptoms

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Sweats easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vertigo or dizziness |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Chills | <input type="checkbox"/> Peculiar taste (describe): |
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Night sweats | _____ |

Respiratory system

- | | | | |
|---|--|--------------------------------------|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Cough | <input type="checkbox"/> Color of phlegm: _____ |
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Wet or dry? _____ |
| | <input type="checkbox"/> Coughing blood | | |

Head, Eyes, Ears ,Nose and Throat

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Excessive Saliva | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Grind teeth | <input type="checkbox"/> Color of phlegm _____ | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> TMJ | | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Other head/neck issues _____ |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Enlarged thyroid | |

Cardiovascular system

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Phlebitis | |

Gastrointestinal system

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Intestinal pain or cramping | <input type="checkbox"/> Bowel movements: |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Itchy anus | <input type="checkbox"/> Frequency: _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Constipation | <input type="checkbox"/> Burning anus | <input type="checkbox"/> Color: _____ |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Odor: _____ |
| <input type="checkbox"/> Hiccups | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Texture/form: _____ |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Mucous stools | <input type="checkbox"/> Anal fissures | |

Musculoskeletal system

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Lower back pain | | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | _____ |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Limited use | _____ |

Skin and Hair

- | | | | |
|-------------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in hair/skin texture | _____ |
| <input type="checkbox"/> Ulceration | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal infection | _____ |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | | |

HEALTH SCREENING HISTORY

Patient Name: _____

List the date of your most recent test or exam.

Mammogram _____ Pap Smear _____ Self Breast Exam _____ Breast Exam by Doctor _____

Blood test for Cholesterol _____ Blood Sugar _____ Other Blood tests _____

Immunizations: Polio _____ Tetanus _____ Hepatitis _____ Pneumonia _____

Flu Shot _____

Test for Blood in stool _____ Rectal Exam _____ Feeling the Prostate _____ Scope Lower Bowel _____

Self Exam Testicle _____ Testicle Exam by Professional _____

Anatomy/Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

YOUR PRIMARY CARE DOCTOR'S NAME _____

DR's PHONE # _____

YOUR PRIMARY CARE DOCTOR'S ADDRESS _____

MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR? _____

This history record has been designed to facilitate our patients continuity of care at AcupunctChi Clinic. This is a confidential record and will be kept in our facility. Information contained here will not be released to anyone without your authorization to do so.

Patient/Guardian's signature_____
Date_____
Practitioner's Signature_____
Date