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	Other	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allen::iies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleedino 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							
MiQraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

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___ _

Anatomv\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# / Email : _____

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

Please confirm your permission and the best way to contact you :

phone _____ email _____ text _____

_____ _____

Patient/Guardian's signature Date Practitioner's Signature Date

REVIEW OF SYSTEMS **Patient Name:**

Neuropsychological

o Seizures	o Depression	o Abuse survivor	o Other (specify):___
o Numbness	o Anxiety	o Considered/attempted	_____
o Tics	o Irritability	suicide	_____
o Poor memory	o Easily stressed	o Seeing therapist	

Genitourinary symptoms

o Pain on urination	o Incontinent	o Wake to urinate	o Impotence
o Frequent urination	o Incomplete urination	o Increased libido	o Premature ejaculation
o Urgent urination	o Venereal disease	o Decreased libido	o Nocturnal emission
o Blood in urine	o Bedwetting	o Kidney stones	o Other: _ _ _ _ _ _

Gynecological symptoms

Age menses began:	o Irregular periods	Date of last	# of pregnancies:
_____	o Clots	PAP:_ _ _ _ _	_____
Length of cycle (day 1 today 1)___ _	Vaginal sores	o Painful period	# of live births:
o Vaginal odor	o Vaginal discharge	o **PMS**	_____
Duration of flow: _ _ . _	o Color:____	o Breast lumps	# of premature births:
Date last period began			_____
_____			Age at menopause:
			_____

Emotional stress scale

1 2 3 4 5 6 7 8 9 10

no stress moderate extremely stressed

Rate your stress level regarding

Work_____ Money_____ Family___ General_____

Health_____ Love _____ Future ____

o **IF NOT NOTED IT IS EITHER NEGATIVE,NON-CONTRIBUTORY,AND/OR NON-PERTINENT.**

Additional Comments _____

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

Marital status: **Education level completed:** **Memories** of **your** childhood: **Do You Find Your Life:**

D Single ☐ High school D Mostly happy D Generally Unsat.
D Married D College D Mostly painful D Too Demanding
D Divorced D Professional school D Normal D Boring
D Widowed D Other: D Don't recall D Satisfactory

D alone ☐family D roommate D significant other
D Children (list sex/ages):_
D Major stresses in last 6 months D Money D Job D Marriage D Home life D Children
D Other stressors: _____

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

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes? D YES D NO If yes, how many? #___ yrs. ___ packs per day
Did you ever smoke? 0 YES ☐ NO If yes, when did you quit? _____
Do you drink alcohol? D YES D NO If yes, how much? Type __ & __ drinks per week

Do you drink caffeinated beverages? 0 YES O NO If yes, which? _____
Do you use recreational drugs? 0 YES ONO If yes, which? _____
Do you manage stress well? 0 YES ONO LJ NOT SURE ONEEDHELP
Do you exercise regularly? 0 YES ONO If no, why? _____
Do you enjoy your job? 0 YES ONO If no, why? _____
Do you allow time to unwind and relax? 0 YES ONO If no, why? _____
Do you sleep soundly? ☐YES ☐NO If no, why? _____
Are you satisfied with your sex life? ☐ YES ☐NO Ifno, why? _____
Are you satisfied with your social life? 0 YES ☐NO If no, why? _____
Are you satisfied with your spiritual life? 0 YES ONO If no, why?
Is your diet healthy enough? 0 YES ONO ☐NOT SURE ☐ 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
_Others_____

REVIEW OF SYSTEMS

Patient Name:

Check any symptoms that currently apply to you:

General symptoms

o Poor appetite
o Heavy appetite
o Strongly like cold drinks
o Strongly like hot drinks
o Recent weight loss
o Recent weight gain

o Poor sleep
o Heavy sleep
o Dream-disturbed sleep
o Fatigue
o Lack of strength
o Bodily heaviness

o Cold hands or feet
o Poor circulation
o Shortness of breath
o Fever
o Chills
o Night sweats

o Sweats easily
o Muscle cramps
o Vertigo or dizziness
o Bleed/bruise easily

o Peculiar taste (describe):
_____

Respiratory system

o Pneumonia
o Difficulty breathing when lying down

o Asthma/wheezing
o Shortness of breath
o Coughing blood

o Cough
o Tight chest

o Color of phlegm:
_____
o Wet or dry? ____ _

Head, Eyes, Ears ,Nose and Throat

o Glasses
o Eye strain
o Eye pain
o Red eyes
o Itchy eyes
o Spots in eyes
o Poor vision
o Blurred vision
o Night blindness

o Glaucoma
o Cataracts
o Teeth problems
o Grind teeth
oTMJ
o facial pain
o Gum problems
o Sores on lips or tongue
oDrymouth

o Excessive Saliva
o Sinus problems
o Excessive phlegm
o Color of phlegm
_____
o Recurrent sore throat
o Swollen glands
o Lumps in throat
o Enlarged thyroid

o Nose bleeds
o Ringing in ears
o Poor hearing
o Earaches
o Headaches
oMigraines
o Concussions
o Other head/neck issues
_____

Cardiovascular system

o High blood pressure
o Low blood pressure
o Blood clots

o Fainting
o Chest pain
o Difficulty breathing

o Tachycardia
o Heart palpitations
o Phlebitis

o Irregular heartbeat

Gastrointestinal system

o Nausea
o Vomiting
o Acid regurgitation
o Gas
o Hiccups
o Bloating

o Bad breath
o Diarrhea
o Constipation
o Laxative use
o Black stools
o Mucous stools

o Intestinal pain or cramping
o Itchy anus
o Burning anus
o Rectal pain
o Hemorrhoids
o Anal fissures

o Bowel movements:
o Frequency_____
o Color: _ _ _ _ _
Odor: _ _ _ _ _
Texture/form: ___

Musculoskeletal system

o Neck/shoulder pain
o Muscle pain
o Upper back pain

o Lower back pain
o Joint pain
o Rib pain

o Limited range of motion
o Limited use

o Other (describe):
_____
_____

Skin and Hair

o Rashes
o Hives
o Ulceration
o Eczema

o Psoriasis
o Acne
o Dandruff
o Itching

o Hair loss
o Change in hair/skin texture
o Fungal infection

o Other (describe)
_____
_____