

## Acupuncture & Natural Medicine Clinic – 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 \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Place of birth \_\_\_\_\_ Age \_\_\_ Height \_\_\_ Weight \_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

\_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ 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 Sleep \_\_\_ Work \_\_\_ other (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 (cups) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_

Marijuana \_\_\_\_\_

Other recreational drugs \_\_\_\_\_

Vitamins & herbs \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Food cravings \_\_\_\_\_

Diet: What might you eat on a typical day?

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Exercise \_\_\_\_\_ How often? \_\_\_\_\_

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) \_\_\_\_\_

\_\_\_\_\_

**MEDICINES:**

Prescription drugs you are currently taking:

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over-the-counter medication you are currently taking:

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MAJOR HOSPITALIZATIONS** If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Date of last physical examination: \_\_\_\_\_

Name & address of physician \_\_\_\_\_

Phone number of physician \_\_\_\_\_

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes/No

**GYNECOLOGY**

Age of first menses: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_ Duration of flow \_\_\_\_\_

Blood clots: yes/no when: \_\_\_\_\_ Length of cycle \_\_\_\_\_

Color of menstrual blood: pale/bright red/dark red/brown other \_\_\_\_\_

Texture of menstrual blood: thick/thin/watery/normal

Pain: yes/no when: \_\_\_\_\_

Irregular periods (describe): \_\_\_\_\_

PMS (please describe): \_\_\_\_\_

Current method of contraception: \_\_\_\_\_ Past method of contraception: \_\_\_\_\_

Are you currently pregnant? yes/no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): \_\_\_\_\_

Urinary tract infections: \_\_\_\_\_ How frequent? \_\_\_\_\_

Vaginal infections/ discharges (describe color): \_\_\_\_\_

Pain/itching of genitalia: \_\_\_\_\_

Pap smear: normal/abnormal Date of last Pap smear: \_\_\_\_\_

Uterine fibroids: \_\_\_\_\_ Endometriosis: \_\_\_\_\_ Other: \_\_\_\_\_

Menopause (date of onset): \_\_\_\_\_ Symptoms: \_\_\_\_\_

Any bleeding since? \_\_\_\_\_

Are you currently on Hormone Replacement Therapy (HRT)? yes/no Dose: \_\_\_\_\_

How long have you been on HRT? \_\_\_\_\_ Any side effects? \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

**General**

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

**Head & Neck**

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

**Ears**

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

**Eyes**

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

**Nose, Throat & Mouth**

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

**Skin**

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

**Respiratory**

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

**Gastrointestinal**

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

**Musculoskeletal**

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

**Neurological**

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

**Genito-urinary**

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

**Infection Screening**

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

**Other**

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