PATIENT MEDICAL HISTORY

Patient Name_____ Date _____/_____/_____

Patient Address_____City_____ State _____Zip_____

Mobile Phone_____ Home Phone_____ Work Phone_____

Gender: Male Female Age_____ DOB _____/_____/_____

Marital Status_____ Weight_____ Occupation_____

Have you received Acupuncture or Chinese herbs in the past? Yes No

Name of Acupuncturist_____ Date of last visit_____ Reason_____

Primary Care Physician_____ Date of last visit_____ Reason_____

This condition is due to: automobile work injury sports/ exercise injury chronic illness other_____

MAJOR COMPLAINT What is your primary reason for this visit?

_____

_____

_____

Date of the injury/ illness?_____ When did your symptoms begin?_____

Did your symptoms develop: gradually suddenly other_____

Is there a pattern to when your symptoms occur? Yes No If yes, what is the pattern:

morning occasionally during sleep What initiates your symptoms? _____

evening intermittently upon waking What makes them worse? _____

all day constantly other_____ What makes them better? _____

Have you received treatment for this complaint? Yes No Did it help? Not at all Somewhat Very effective Not sure

Have any other family members had the same or similar complaint ? Yes No

FAMILY HEALTH HISTORY (illness or conditions seen in other family members) circle all that apply

asthma	allergies	bleeding easily	cancer	diabetes
digestive problems	emotional problems	heart disease	high blood pressure	kidney disease
mental illness	obesity	seizures	stroke	substance abuse

other_____

Father	living - age _____	deceased - age at death_____	cause_____
Mother	living - age _____	deceased - age at death_____	cause_____
Spouse	living - age _____	deceased - age at death_____	cause_____

Siblings	age _____	M	F	health status_____
Siblings	age _____	M	F	health status_____
Siblings	age _____	M	F	health status_____
Children	age _____	M	F	health status_____
Children	age _____	M	F	health status_____
Children	age _____	M	F	health status_____

PERSONAL HISTORY

How would you describe your health as a child? _____

Circle any illnesses or conditions you have or had in the past:

AIDS/HIV	alcoholism	allergies	antibiotic use	asthma	bleed easily
cancer	chicken pox	diabetes	epilepsy	glaucoma	heart disease
hepatitis	high blood pressure	high fevers	jaundice	kidney disease	measles
meningitis	mental disorders	multiple sclerosis	mumps	pacemaker	pneumonia
polio	rheumatic fever	scarlet fever	stroke	thyroid disorders	tuberculosis
typhoid fever	ulcers	vascular disease	venereal disease		

other _____

List illnesses NOT requiring surgery for which you have been hospitalized (including date):

_____

_____

List illnesses requiring surgery (including date):

_____

_____

List allergies or sensitivity to any medicine or other substances:

_____

_____

Current medications (please include dietary supplements, herbs etc.):

_____

_____

Check the diseases against which you have been immunized:

Diphtheria/ Pertussis/ Tetanus Tetanus only Measles/ Mumps/ Rubella Influenza

Typhoid Hepatitis B Varicella (chicken pox) Other _____

Medical Tests; list latest results

Date	Test	Result	Date	Test	Result
	Physical			Stool	
	Cholesterol			HIV test	
	Hepatitis			PSA (prostate)	
	Mammography			Other	
	Pap Smear			Other	

Comments (anything else you would like to tell me): _____

_____

I state that all information on this form is correct, to the best of my knowledge. I understand that I am responsible for payment of all fees at the time of service unless arrangements have been made in advance.

Patient Signature_____ Date_____/_____/_____

Consent to treat a minor child:

I hereby authorize treatment to my child : (child's name)_____

Parent/ Legal Guardian signature _____Date_____/_____/_____