Personal Information

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Occupation_____ E-Mail Address_____

Social Security Number:_____/_____/_____ Spouses Name_____

From who and/or how did you hear about my practice?_____

Sex: M/F Height:_____ Weight:_____ Birthdate:_____ Age:____

Marital Status: Married Single Divorced Widowed # of Children:_____

Have you received acupuncture therapy before? Yes/No When?_____
With whom?_____

Personal Health History: Check the appropriate box if you have experienced any of the following:

- ☐ Adverse reaction to medical treatment
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis or rheumatism
- ☐ Artificial heart, valve or joints
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Cancer or Tumor
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eye Disorder
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis, jaundice or Liver disorder
- ☐ Herpes
- ☐ High Blood pressure
- ☐ Immune Disorder
- ☐ Kidney Disorder
- ☐ Low Blood Pressure
- ☐ Musculo-skeletal Disorder
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Respiratory Disorder
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Seizures/Epilepsy
- ☐ Skin Disorders
- ☐ Special Diet
- ☐ Stomach or Intestinal Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transfusion (before March 1985)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Disorder
- ☐ Venereal Disease
- ☐ Other:_____

Is there anything we should know about your medical history?_____
_____
_____
_____

Who is your current Healthcare Provider? _____
Address_____
Phone_____ Date of Last Physical_____

What is your:
Height? _____ Usual Blood Pressure? _____
Weight? _____ Weight, 1 yr ago? _____

FAMILY HISTORY: Complete for each family member. Place X in box indicating any illnesses they ever had								
	Mother	***Father***	***Grdmother***	***Grdfather***	***Sister***	***Brother***	***Spouse***	***Children***
Allergies								
Anemia/Blood Dis								
Cancer or Tumors								
Chemical Dependency								
Diabetes								
Heart Disease								
High Blood Pressure								
Kidney or Bladder Dis								
Seizures / Epilepsy								
Stomach-Intestinal Dis								
Stroke								
Tuberculosis								
Other								
Age at Death								

Major Hospitalizations: If you have even been hospitalized for any serious medical illness or surgery, write in your most recent hospitalizations below. *Check this box ☐ if you have had more than three such hospitalizations.* (Do not include normal pregnancies).

1st Hospitalization_____
Year Operation/Illness Hospital/City/State

2nd Hospitalization _____
Year Operation/Illness Hospital/City/State

3rd Hospitalization _____
Year Operation/Illness Hospital/City/State

Medications & Supplements: Check the box next to any of the following that you are now taking.

☐ Antacids	☐ Allergy medication	☐ Sleeping pills
☐ Aspirin	☐ Ibuprofen/Advil	☐ Tranquilizers
☐ Cold tablets	☐ Laxatives	☐ Herbs
☐ Diet pills	☐ Oral Contraceptives	☐ Vitamins
☐ Diuretics	☐ Blood pressure medication	☐ Antidepressants
☐ Tylenol	☐ Prescription pain medication	☐ Hormone replacement therapy
☐ Viagra	☐ DHEA/ melatonin/ Beta HCG	☐ Yohimbine/ Yohimbe

Please list any medications that you are currently taking that are not listed above:

_____ _____ _____

_____ _____ _____

Please list any medication allergies you have:

_____ _____ _____

_____ _____ _____

Habits: Please mark any of the habits listed below which apply to you. Mark "**X**" for current habits. Mark "✓" for past habits.

Use of tobacco: ☐ Yes ☐ No If yes, # of cigarettes/day _____ age started_____

Use of alcohol: ☐ Yes ☐ No If yes, # of drinks per week _____ age started_____

Use of Caffeine: ☐ Yes ☐ No # colas / day____ # coffee / day ____ # tea / day____

Previous Pregnancies: Please fill in completely.

Year	Length of Preg	Labor Hours	Type of Delivery	Sex	Weight	Name

1. _____

Complications_____

2._____

Complications_____

3._____

Complications_____

What are your primary health concerns?_____
_____

Please list any secondary health concerns you may:

_____ _____

_____ _____

Tell us about your lifestyle:

What sort of diet do you have? (check one) ☐ Standard American ☐ Weight loss type
☐ Fast/Quick Prep Diet ☐ Vegetarian ☐ Vegan ☐ Low Fat ☐ Low Carbs
☐ Muscle Building Diet ☐ Balanced Food Groups ☐ Other_____
Is Nutrition or Diet something you'd like to improve or be evaluated for? ☐ Yes ☐ No

Are you active? (check one) ☐ Sedentary Job w/o exercise ☐ Sedentary Job w/ Much Exercise
☐ Sedentary Job w/ Some Exercise ☐ Active Job w/o Extra Exercise ☐ Active Job w/ Exercise
What type of exercise do you do?_____
Would you like evaluation for the best form of exercise for your body and health? ☐ Yes ☐ No

How would you characterize your life in terms of stress?: (check one)
☐ High Stress ☐ Much Stress ☐ Fairly Stressed ☐ Mild Stress ☐ Periodic Stress ☐ Not Stressed
Would you like to be handling stress better, or reduce the effects of stress? ☐ Yes ☐ No

Do you experience any of the following moods often? (check all that apply)
☐ Depression ☐ Anxiety ☐ Insecurity ☐ Anger ☐ Irritabililty ☐ Phobias ☐ Nervousness
☐ Mood Swings ☐ Sadness ☐ Short Tempered ☐ Obsessive Thinking ☐ Isolated ☐ Hopelessness
Would you like to be evaluated for possible treatment solutions for these states? ☐ Yes ☐ No

Please check the treatment methods with which are you most comfortable:

☐ Traditional Western Medicine	☐ Holistic Medical Care by MD	☐ Acupuncture
☐ Chiropractic Care	☐ Nutrition and dietary counseling	☐ Exercise
☐ Chinese Herbology	☐ Physical Therapies, such as Massage	☐ Western Medication
☐ Energetic Treatment	☐ Vitamin & Mineral Supplementation	☐ Lab Work & Exam
☐ Movement Therapy	☐ Counseling/ Psychotherapy	☐ Western Herbal Medicine
☐ Structural Treatment	☐ Meditation/ Stress Reduction	☐ Detoxification & Cleansing

In which of the following areas of life are you satisfied?

☐ Your work ☐ Your relationships ☐ Your family ☐ Your spiritual life ☐ Your health ☐ Your security