NEW PATIENT INFORMATION

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

Name:_____ Date:_____

Date of Birth:_____ M / F Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Day Phone:_____ Evening Phone:_____ Fax:_____

Email:_____

Occupation:_____ Employer's Name/Address:_____

_____

Referred by:_____

Are you currently under the supervision of a medical doctor? Yes / No

Physician's Name & Phone Number:_____

Reason for today's visit:_____

Is this your first acupuncture treatment? Yes / No

Family History	IF LIVING		IF DECEASED	
		HEALTH	DEATH AGE	CAUSE OF DEATH
	AGE	Good Fair Poor		
Father				
Mother				
Sibling (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband □ Wife □ Partner □				
Children (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Have you or any blood relatives had any of these conditions?

	Yes	No	Relationship		Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Kidney Disease			
Allergies				Leukemia			
Anemia				Mental Disorders			
Alcoholism				Migraine			
Bleeding Tend.				Nervous Breakdown			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease				Other (please list)			

HABITS Daily Consumption
Do you smoke? Y / N _____ Pkgs.
Drink Coffee? Y / N _____ Cups
Drink Alcohol? Y / N _____ oz.
Fall Asleep Easily? Y / N
Awaken Early? Y / N

WHAT MEDICATIONS &/OR SUPPLEMENTS ARE YOU CURRENTLY TAKING?_____
_____
_____
_____

Operations you have had: Year
_____
_____

Diseases you have had requiring hospitalization: Year
_____
_____

Serious Illness Not requiring hospitalization: Year
_____
_____

Drugs you are allergic to:_____
_____

Describe any serious injuries or accidents you have had:_____
_____
_____

WOMEN ONLY - Please check all that apply: Are you still having regular monthly periods? Y / N

Bleeding between periods? ___ Depression? ___ Used birth control? _____
Discharge? ___ Irritability? ___ Dates_____
Heavy Bleeding? ___ Miscarriage? ___ How Many?_____ How many days cycle? _____
Bloating? ___ Gas? ___ No. of children born alive?_____ How many days flow? _____
Pain? ___ Headaches? ___ No. of stillbirths? _____ Clotting? ___
Low Back Pain? ___ Complications with pregnancy? _____ Dark purple blood? ___
Cramping? ___ No. of stillbirths? _____ Brownish Blood? ___

Are you or do you suspect that you might be pregnant now? Yes / No If yes, how many months? _____

MEN ONLY – Please check all that apply:

Loss of sexual activity? ___ Treatment for genitals? ___ Prostate trouble? ___
Discharge from penis? ___ Hernia (rupture)? ___ Òther? _____

MEN AND WOMEN – Please check all that apply:

Headaches? ___ Chest tightness? ___ Undigested food in stool? ___
Dizziness? ___ Shortness of Breath? ___ Mucous in stool? ___
Ringing in the ears? ___ Palpitations (feeling heartbeat?) ___ Fatigue? ___
Convulsions? ___ Pain in calves when walking? ___ Excessive Thirst? ___
Blurred vision? ___ Tingling in legs at night? ___ Low Thirst? ___
Coughing / Wheezing? ___ Trouble sleeping? ___ Excessive Appetite? ___
Stuffy/Runny Nose? ___ Anxiety-filled dreams? ___ Low Appetite? ___
Acid Reflux / Heartburn? ___ Difficult or frequent urination? ___ Recent Weight Gain? ___
Bad taste in mouth? ___ Blood in urine? ___ Recent Weight Loss? ___
Loss of appetite? ___ Kidney stones? ___ Low Back Pain? ___
Bleeding gums? ___ Pain in abdomen? ___ Knee Pain? ___
Sore throat? ___ Constipation? ___ Cold Hands & Feet? ___
Sweating other than with exertion? ___ Diarrhea? ___ Numbness? Where?_____

Do you exercise regularly? Y / N How often (Hours/Days per week)_____
What type of exercise do you perform? _____
Please describe any injuries: