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## • PATIENT INFORMATION FORM •

Please fill out as completely as possible. The information you include here is confidential, and will be used to help determine the best course of treatment for you. If you have questions about any items on the form, please ask. Thanks for your time.

| | | | |
|---|---|---|---|
| Name | | | Today's Date |
| Street Address | | | |
| City | | State | Zip |
| Home Phone | | Email | |
| Occupation | | | Work Phone |
| Emergency Contact: Name | | | Phone |
| Who may I thank for referring you? | | | |
| Sex ◯ Male ◯ Female | Height | Weight | Birthdate |
| Have you received acupuncture or Chinese herbal therapy before? Yes ☐ No ☐ | | | |
| Previous practitioner | | When treated? | |

| Please list the major concern(s) that brought you here today: | |
|---|---|
| Concern | How long? |
| 1.<br>2.<br>3.<br>4.<br>5. | 1.<br>2.<br>3.<br>4.<br>5. |
| What other forms of treatment have you explored for these concerns? | |

| Please list any medications or nutritional supplements you are currently taking (use back of sheet if necessary): | |
|---|---|
| Name of medication/supplement | Dosage |
| Please describe your typical daily eating habits: | |
| Breakfast:<br><br>Lunch: | Dinner:<br><br>Snacks: |
| How many alcoholic beverages do you drink weekly? | |
| Are you a smoker?<br>If so, how many times a day do you use tobacco? | |
| How many cups of coffee, tea or other caffeinated beverage do you consume daily? | |
| How much water do you drink daily? | |

## • Medical History •

Please indicate any history of the following illnesses or conditions in you or your family:

| Illness | You | Family Member | When? | Illness | You | Family Member | When? |
|---|---|---|---|---|---|---|---|
| Cancer | | | | Emotional Disorders | | | |
| Heart Disease | | | | Tuberculosis | | | |
| High Blood Pressure | | | | Seizures | | | |
| Diabetes | | | | Stroke | | | |
| Thyroid Disorder | | | | Neurological Disorders (e.g. Parkinson's) | | | |
| Hepatitis | | | | Sexually Transmitted Diseases | | | |
| Congenital Disorders (from birth) | | | | HIV/AIDS | | | |

Please list any accidents, surgeries, or hospitalizations (include birth deliveries, C-sections, elective surgeries and cosmetic surgeries; also include date of occurrence):

Other (please specify):

## • Lifestyle Inventory •

How do you feel about the following aspects of your life? Please check the applicable box and include any relevant comments.

| | Great | Good | OK | Poor | Bad | Comments |
|---|---|---|---|---|---|---|
| Life partner | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Family | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Diet | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Sex Life | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Self Image | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Work | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Exercise | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Spirituality | ☐ | ☐ | ☐ | ☐ | ☐ | |

Please rank the following statements as they apply to your life.
(1 = most important, 5 = least important):

___To be in control ___To be loved ___To be needed ___To be correct ___To be safe

## • For Women Only •

| | | | |
|---|---|---|---|
| Age of 1st period (menarche) | Are you pregnant? Yes ☐ No ☐ | | # of pregnancies |
| Age of last period (menopause) | # of live births | # of abortions | # of miscarriages |
| # of days between periods | Date of last GYN exam: | | Date of last Pap smear: |
| # of days of flow | Date of last mammogram: | | Date of last Bone density scan: |
| Color of flow | | | |
| Clots? Yes ☐ No ☐ | Average # of pads you use per day of cycle: | | |
| If yes, what color: | 1st day | 2nd day | 3rd day | 4th day | + day(s) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Have you been diagnosed with (circle all that apply): | Fibroids | Fibrocystic Breasts | Endometriosis | Ovarian Cysts | PID | Infertility | Other |

| Nature of menstrual pain (check all that apply) | | |
|---|---|---|
| Cramping ☐ | Stabbing ☐ | |
| Burning ☐ | Aching ☐ | |
| Dull ☐ | Bloating ☐ | |
| Constant ☐ | Intermittent ☐ | |
| Bearing Down Sensation ☐ | | |
| Other: | | |

| Location of Menstrual Pain (check all that apply) |
|---|
| Lower Abdomen ☐ |
| Lower Back ☐ |
| Thighs ☐ |
| Side of Ribcage ☐ |
| Other: |

| Other symptoms related to menstrual cycle (check all that apply) | | |
|---|---|---|
| Vaginal Discharge ☐ | Vaginal Dryness ☐ | Headache ☐ |
| Nausea ☐ | Constipation ☐ | Diarrhea ☐ |
| Swollen Breasts ☐ | Mood Swings ☐ | Ravenous Appetite ☐ |
| Loss of Appetite ☐ | Hot Flashes ☐ | Night Sweats ☐ |
| Increased Libido ☐ | Decreased Libido ☐ | Insomnia ☐ |
| Other: | | |

## • For Men Only •

| | | |
|---|---|---|
| Date of last prostate exam | PSA results | Manual prostate exam results |
| Frequency of Urination<br># of times during day:<br># of times after bedtime: | Color of Urine (check one)<br>Clear ☐<br>Pale yellow ☐<br>Yellow Dark ☐<br>yellow other ☐ | Other qualities noted (circle below)<br>Unusual Odor ☐<br>Cloudy ☐<br>Bloody ☐ |

### Other symptoms (mark all that apply):

| | | |
|---|---|---|
| Delayed urine stream ☐ | Dribbling urination ☐ | Incontinence ☐ |
| Urinary retention ☐ | Rectal dysfunction ☐ | Back pain ☐ |
| Back pain ☐ | Groin pain ☐ | Testicular pain ☐ |
| Premature ejaculation ☐ | Erectile dysfunction ☐ | Other: |
| Increased libido ☐ | Decreased libido ☐ | |