Acupuncture For Life
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During your first visit, we hope to come to understand your health concerns, answer questions you may have and give you an examination using the Asian Medical approach. After your examination we will review the results together and look at options available for treatment of your condition. If you elect to undertake treatment, we will begin as soon as possible. Treatment often begins at one's first visit.

It is important that you are on time for all appointments. A certain amount of time is allotted for each patient visit. If you are late, your remaining time may not be sufficient for your full treatment. The office visit fee will still apply.

We are committed to seeing that all of our patients are given the opportunity to receive appropriate Acupuncture/health care. If you find any of the conditions of treatment difficult to meet, please feel free to talk to us about them and we will make arrangements together accordingly. Initial Office visit and consultation is currently $125.^{00}$. Should you need to reschedule your visit, please contact our office a minimum of one full business day in advance, to avoid the office visit fee.

PLEASE NOTE: ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Some of the questions that follow may seem unrelated to your condition: they do however play a major role in diagnosis and successful treatment.

PLEASE PRINT

Name _____ Date _____/_____/_____

Address_____ City_____ State_____ Zip_____

Phone No.(____)_____ Work No. (____)_____E. Mail_____ _____

Age:_____ Sex:_____ Height ____'____" Weight _____lb. Date of Birth ____/____/___

Place of Birth _____

Marital Status: _____ Occupation _____ Employer _____

Who is your medical doctor?_____Date of last visit_____Reason_____

Have you received Acupuncture/Chinese herbs in the past?_____

How do you plan to handle your account? (Circle one) Cash, Check, MC, Visa

Party responsible for payment _____In case of emergency notify _____

Their relationship to you_____ Their phone _____

Diagnosis/Major Health Complaint_____

Health Professionals Seen for This Condition_____

How, When, And Where Did This Condition Begin_____

How Does This Condition Impair Your Daily Activities_____

Is There a Pattern to When your Symptoms Occur ie. Morning, Evening, Occasionally, Constantly, etc.

_____

Please List the Main Health Problems You Would Like to be Free of in Order of Importance:

1. _____

2. _____

3. _____

<u>*Do you have a pacemaker?</u> Y N

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:_____

_____

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past) Neck /Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain Low Back Pain Leg Pain Foot/Ankle Pain Wrist Pain Knee Pain Hip Pain Elbow Pain

Pain is (check all that apply): sharp [ ] burning [ ] moving [ ] fixed [ ] dull [ ] aching [ ] stabbing [ ] radiates to: _____

Anything make it better or worse? (ie. Cold, Heat, Rest, Activity)_____

_____

Emotional (please circle any that you experience now and underline any that you have experienced in the past): Mood Swings Nervousness Anxiety Mental Tension Forgetfulness Depression

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past): Fatigue Frequent Common Colds Slow Wound Healing Chronic Infections Low Energy Chronic Fatigue Syndrome Fibromyalgia

Head, Eye, Ear, Nose and Throat (please circle any that you experience now and underline any that you have experienced in the past): Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Allergies/Hay Fever

Respiratory (please circle any that you experience now and underline any that you have experienced in the past): COVID-19 Pneumonia Persistent Cough Bronchitis Difficulty Breathing Emphysema Asthma Tuberculosis Shortness of Breath
Other Respiratory Problems:_____
Have you been vaccinated? _____ Are you boosted? _____
Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past): Heart Disease Chest Pain High Blood Pressure Swelling of Ankles Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal(please circle any that you experience now and underline any that you have experienced in the past): Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn Belching Gallbladder Disease Liver Disease Hepatitis B or C Hemorrhoids Diarrhea Blood in Stool Constipation Jaundice

Genito-Urinary Tract(please circle any that you experience now and underline any that you have experienced in the past): Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow Kidney Stones Impaired Urination Blood in Urine Night-time Urination Bed Wetting Incontinence

WOMEN ONLY FILL IN THIS PORTION

Do you have any reason to believe you may be pregnant? Y N If so, date of missed cycle?_____ If no, when was the first day of your last cycle?_____
Are your cycles regular? Y N If no, please explain_____
Age at first period?_____ #Days between periods?_____ #Days of bleeding?____
Amount of bleeding: Light/Moderate/Heavy Are there clots? Y N If yes, how large?___
Bleeding between cycles? Y N Pain with bleeding? Mild/Moderate/Heavy
Pain starts with the onset of bleeding? Y N If No, please explain when and if pain exists_____ Do you experience PMS? Y N Cravings? Y N
What do you crave?_____ Do you have pain with ovulation? Y N
Are you experiencing a vaginal discharge? Y N If so, is there itching or burning or an unusual odor?_____ When was your last Pap Smear?_____
Result?_____ Have you ever had an abnormal Pap? Y N If yes, what follow up was needed?_____ What form of Contraception do you use?_____
For how long?_____ Difficulty in Conceiving? Y N If yes, explain_____

# of Pregnancies?_____ # of births?_____ #of Miscarriages?_____ # of Abortions?_____ Difficult Labors? Y N Please describe_____

Menopause? Y N Age of Onset?_____ Hotflashes/Night Sweats? Y N If yes, please describe:_____

MEN ONLY FILL IN THIS PORTION

1. Do you ever experience burning, urgency or other discomfort during urination? Yes[ ] No[ ]
2. Have you ever been diagnosed with prostatitis? Yes[ ] No[ ]
3. Do you have any concerns about sexual function? Yes[ ] No[ ]

Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Multiple Sclerosis

Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemic Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Skin/Hair (please circle any that you experience now and underline any that you have experienced in the past):

Rashes Eczema Hives Psoriasis Skin Cancer Thinning Hair Grey Hair Dry Skin

Sleep (please circle any that you experience now and underline any that you have experienced in the past):

Insomnia Disturbed Sleep Difficulty Going Back to Sleep Vivid Dreams

Other (please circle any that you experience now and underline any that you have experienced in the past):

Cancer (if so please explain)_____ HIV/Aids Anemia

Lifestyle:

What do you eat?_____

Food sensitivities/allergies:_____

Do you typically eat at least three meals per day? Y N If no, how many?_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day?_____

What is your exercise routine?_____

How many hours per night do you sleep?_____ Do you wake rested? Y N

Nicotine/Alcohol/Caffeine Use:_____

Have you experienced any major traumas? Y N Explain:_____

Hospitalizations/Surgeries:_____

Childhood Illnesses: Scarlet Fever Diptheria Rheumatic Fever Mumps Measles Chicken Pox
Others:_____

Immunizations: Polio Tetanus Measles Mumps Rubella Pertussis Diptheria Hib HepB
Other:_____

List date and results of last medical test: Physical_____ Cholesterol_____ Mammography_____
PSA_____ Pap smear_____ Other_____

Interest and Hobbies:_____

How did you hear about us?_____

Any other comments that would help us better serve you_____

Print Name:_____

Signature:_____ Date:_____