

## 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.<sup>00</sup>. 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.

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Please List The Main Health Problems You Would Like To Be Free Of In Order Of Importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**\*Do you have a pacemaker?** 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): Pneumonia Persistent Cough Bronchitis Difficulty Breathing Emphysema  
Asthma Tuberculosis Shortness of Breath Other Respiratory Problems:\_\_\_\_\_

**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: \_\_\_\_\_

<b><u>MEN ONLY FILL IN THIS PORTION</u></b>	
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 Diphtheria Rheumatic Fever Mumps Measles Chicken Pox  
Others: \_\_\_\_\_

Immunizations: Polio Tetanus Measles Mumps Rubella Pertussis Diphtheria 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:** \_\_\_\_\_