

ACUPUNCTURE *of Orlando*

Patient Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____ Phone _____

E-mail Address _____ Cell Phone: _____

Business Address _____

City _____ State _____ Zip _____ Phone _____

Occupation _____

Place of Birth _____

Date of Birth _____ Age _____ Height _____ Weight _____ Soc. Sec. # _____

Sex _____ Marital Status (Single, Married, Life Partner, Divorced, Widowed) _____

In Case of Emergency Notify _____ Phone# _____

How did you hear of this office? _____

Have you ever before tried acupuncture or Chinese herbal medicine? _____

CHIEF COMPLAINT

What are the main health problems for which you are seeking treatment? _____

Please rate the extent to which your current complaint affects your daily life (1 = minor; 10 = major) _____

Please rate your commitment to resolving this problem (1 = minor; 10 = major) _____

What other forms of treatment have you sought? _____

PAST MEDICAL HISTORY (check all which apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Birth Trauma (see pp. 4-6) |
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Childhood Illnesses | <input type="checkbox"/> Accidents |
| <input type="checkbox"/> Significant Trauma | <input type="checkbox"/> Medications | <input type="checkbox"/> Other (please specify) |

FAMILY MEDICAL HISTORY (check all which apply and specify which blood relative)

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other (please specify) | |

LIFESTYLE (please indicate the use and frequency of the following)

- | | | |
|---|--|--|
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Black Tea | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Caffeinated Beverages | <input type="checkbox"/> Recreational Drug |
| <input type="checkbox"/> Exercise (please specify type) | | |

MEDICATIONS

Please list any medications and/or supplements you are currently taking _____

GENERAL HEALTH (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Disturbed Sleep | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Cold Hands and Feet | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Cold Abdomen |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Large Appetite | <input type="checkbox"/> Localized Weakness |
| <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Bruise/Bleed Easily | <input type="checkbox"/> Sweat Easily |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Chills | <input type="checkbox"/> Sudden Energy Drop |
| <input type="checkbox"/> Soft/Brittle Nails | <input type="checkbox"/> Catch Colds Easily | <input type="checkbox"/> Other (please specify) |

SKIN AND HAIR

- | | | |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Redness | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Other (please specify) |

HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Spots in Eyes | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Sores on Lips/Tongue | <input type="checkbox"/> Dry Mouth/Throat | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Jaw Clicking |
| <input type="checkbox"/> Toothaches | <input type="checkbox"/> Other (please specify) | |

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Other (please specify) |

RESPIRATORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Coughing Phlegm |
| <input type="checkbox"/> Pain with deep breath | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Other (please specify) |

GASTROINTESTINAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Abdominal Pain/Cramps | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Retention of Food in Stomach | <input type="checkbox"/> Lack of Appetite |
| <input type="checkbox"/> Excessive Appetite | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Sensitive Abdomen | <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Other (please specify) |

GENITO-URINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Decrease in Urine Flow | <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Waking at Night to Urinate | <input type="checkbox"/> Other (please specify) | |

REPRODUCTIVE/GYNECOLOGICAL

Age of 1 st Period _____	Age at menopause _____	# Pregnancies _____
# Live Births _____	# Premature Births _____	# Miscarriages/Abortions _____
# days between periods _____	# days of flow _____	Color of blood _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Clots (Color _____) | <input type="checkbox"/> Painful Menses | <input type="checkbox"/> Irregular Menses |
| <input type="checkbox"/> Premenstrual Symptoms | <input type="checkbox"/> Strong Menstrual Odor | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Vaginal Odor | <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Breast Lumps/Swellings | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Positive Mammogram/Pap Smear | <input type="checkbox"/> Other (please specify) |

MUSCULO-SKELETAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Foot/Ankle Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Other Joint/Bone Problems (please specify) | |

NEURO-PSYCHOLOGICAL

- | | | |
|---|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Lack of Coordination |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Easily Stressed | <input type="checkbox"/> Attempted Suicide |
| <input type="checkbox"/> Treated for Emotional Problems | | <input type="checkbox"/> Other (please specify) |

Because an acupuncture physician must be aware of existing physical conditions, I have stated all known medical conditions and take it upon myself to keep the acupuncture physician updated on my physical, mental, and emotional health.

Signature: _____ Date: _____

