New patient form **Today's date**: _____

Name: _____ SS# _____ Birthdate: _____

Phone: _____ Email: _____ Age: _____

Address: _____ Marital status:

City / State / Zip _____

Work number: _____ Occupation: _____

Emergency contact, name : _____ Tele: _____

Referred by: _____

Reason for visit: _____

How long have you had this condition? _____ Is it getting worse? Y/N

Does it bother your: Sleep / Work / Other (What?)

What seemed to be the initial cause? _____

What seems to make it better? _____

Have you ever had acupuncture? Y/N Chinese Herbal Medicine? Y/N

Are you under the care of a physician now? Y/N If yes, for what?

Physician's name & number: _____

Other concurrent therapies: _____

Health insurance info: Insurance Co name/address/policy number: _____

_____

Family Medical History:

Allergies	Arteriosclerosis	Heart disease	Seizures
Asthma	Cancer	High Blood Pressure	Stroke
Alcoholism	Diabetes		

Your Past Medical History:

(Check aar a sig ificant pa t of your edi al histor y.)

Aids/HIV	Epilepsy	Polio
Alcoholism	Goiter	Rheumatic Fever
Allergies	Gout	Scarlet Fever
Appendicitis Arteriosclerosis	Heart Disease	Seizures
Arthritis	Hepatitis	Stroke
Asthma	Herpes	
Birth Trauma	High Blood Pressure Measles	
Cancer	Multiple Sclerosis Mumps	
Chicken Pox	Pacemaker	
Diabetes	Pleurisy	
Emphysema	Pneumonia	
Surgery (List)	Thyroid disorders	
_____	Major Trauma	
_____	Other (specify)	
_____	(car, fall, etc)	
Tuberculosis	_____	
Typhoid fever	_____	
Ulcers		
Venereal disease		
Whooping cough		

Current Medications: (dosage and frequency)

Current Medications: (dosage and frequency)

Appetite: Low/High
Coffee
Artificial sweetner
Sugar

Thirst for water:
(glasses per day)
Soft drinks

Salty food

Vitamins:

Your lifestyle:

Tobacco
Drugs
Occupational hazards

Exercise/type:
Marijuana

Stress

General Symptoms:

Poor appetite
Heavy appetite
Strongly like cold drinks
Strongly like hot drinks
Recent weight loss/gain
Poor sleep

Fever
Chills
Lack of strength
Bodily heaviness
Cold hands or feet
Poor circulation
Heavy sleep

Shortness of breath
Night sweats
Muscle cramps
Vertigo or dizziness
Bleed or bruise easily
Peculiar taste (describe)
_____

Head, eyes, ears, nose & throat:

Eye strain
Eye pain
Red eyes
Itchy eyes
Glasses
Cataracts
Spots in eyes
Poor vision
Blurred vision
Night blindness
Glaucoma
Grinding teeth
Teeth problems
TMJ

Facial Pain
Gum problems
Sores on lips
Dry Mouth
Excessive saliva
Sinus problems
Swollen glands
Lumps in throat
(Color of phlegm)
Enlarged thyroid
Sinus problems
Excessive phlegm
Recurrent sore throat
Nose bleeds
Poor hearing

Earaches
Ringing in ears
Headaches
Migraines
Concussion
Neck problems:

Respiratory:

Difficulty breathing
When lying down:
Shortness of breath
Tight Chest

Asthma/wheezing
Cough blood?
Cough (wet/dry)
(thick or thin)

Pneumonia

Cardiovascular:

Chest pain	Phlebitis	High blood pressure
Fast heart rate	History of blood clots	Low blood pressure
Slow heart rate	Irregular heartbeat	
Heart palpitations	Difficulty breathing	

Gastrointestinal:

Nausea	Laxative use	Bowel movements:
Vomiting	Black stools	Frequency:
Acid regurgitation	Bloody stools	Color:
Gas	Mucous in stools	Texture/form:
Hiccup	Intestinal pain or cramping	Odor:
Bloating	Itchy/burning anus	
Bad breath	Rectal pain	
Diarrhea	Hemorrhoid	
Constipation	Anal fissures	

Musculoskeletal:

Neck/Shoulder pain	Rib pain	
Muscle pain	Limited range of motion	
Upper back pain	Limited use	
Joint pain	Other:	

Skin and Hair:

Rashes	Psoriasis	Hair loss
Hives	Acne	Change in hair/skin texture
Ulcerations	Dandruff	Fungal infections
Eczema	Itching	Other hair or skin problems:

Neuropsychological:

Seizures	Depression	Abuse survivor
Numbness	Anxiety	Considered/attempted suicide
Tics	Irritability	Other:
Poor memory	Easily stressed	

Genito-urinary

Pain on urination	Venereal disease	Premature ejaculation
Frequent urination	Bedwetting	Nocturnal emission
Urgent urination	Wake to urinate	
Blood in urine	Increased libido	
Unable to hold urine	Decreased libido	
Incomplete urination	Kidney stone Impotence	

Gynecology:

Age menses began:	PMS	# Live births
Length of cycle (day1 to day1)	Vaginal discharge (color)	Age at menopause
Duration of flow	Vaginal sores	Date of last PAP:
Irregular periods	Vaginal odor	Date last period began:
Painful periods	Breast lumps	Date of last mammogram:
Clots	# Pregnancies	

Other health history not mentioned: