## NEW PATIENT INFORMATION

*All information is treated as confidential unless you grant permission to release it. Please print and complete all information.*

Name:_________________________________________ Date:______________

Date of Birth:_______________________ M / F Age:______________

Address:_________________________________________ City:_____________________ State:__________ Zip:___________

Day Phone:_____________________ Evening Phone:_________________________ Fax:_________________________

Email:_________________________________________________________________

Occupation:___________________________ Employer's Name/Address:_____________________________________________

_____________________________________________________________________________________________________

Referred by:____________________________________________________________

Are you currently under the supervision of a medical doctor? Yes / No

Physician's Name & Phone Number:___________________________________________________________________________

Reason for today's visit:___________________________________________________________________________________

Is this your first acupuncture treatment? Yes / No

| **Family History** | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|
| | | HEALTH | DEATH AGE | CAUSE OF DEATH |
| | AGE | Good Fair Poor | | |
| Father | | | | |
| Mother | | | | |
| Sibling (Circle Sex) | | | | |
| 1. M F | | | | |
| 2. M F | | | | |
| 3. M F | | | | |
| 4. M F | | | | |
| 5. M F | | | | |
| Husband □<br>Wife □<br>Partner □ | | | | |
| Children (Circle Sex) | | | | |
| 1. M F | | | | |
| 2. M F | | | | |
| 3. M F | | | | |
| 4. M F | | | | |
| 5. M F | | | | |
| 6. M F | | | | |

| Have you or any blood relatives had any of these conditions? | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Yes | No | Relationship | | Yes | No | Relationship |
| Asthma | | | | Hay Fever | | | |
| Arthritis | | | | Kidney Disease | | | |
| Allergies | | | | Leukemia | | | |
| Anemia | | | | Mental Disorders | | | |
| Alcoholism | | | | Migraine | | | |
| Bleeding Tend. | | | | Nervous Breakdown | | | |
| Cancer | | | | Obesity | | | |
| Colitis | | | | Rheumatism | | | |
| Congenital Heart | | | | Rheumatic Fever | | | |
| Diabetes | | | | Stroke | | | |
| Epilepsy | | | | Suicide | | | |
| Goiter | | | | Stomach Ulcers | | | |
| High Bl. Press. | | | | Tuberculosis | | | |
| Heart Disease | | | | Other (please list) | | | |

**HABITS** Daily Consumption
Do you smoke? Y / N ______ Pkgs.
Drink Coffee? Y / N ______ Cups
Drink Alcohol? Y / N ______ oz.
Fall Asleep Easily? Y / N
Awaken Early? Y / N

**WHAT MEDICATIONS &/OR SUPPLEMENTS ARE YOU CURRENTLY TAKING?**_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

**Operations you have had**: Year
_______________________________________
________________________________

**Diseases you have had requiring hospitalization:** Year
___________________________
___________________________

**Serious Illness Not requiring hospitalization:** Year
________________________
________________________

**Drugs you are allergic to:**____________________________________
______________________________________

**Describe any serious injuries or accidents you have had:**_____________________________________________
_______________________________________________
_______________________________________________

**WOMEN ONLY -** Please check all that apply: Are you still having regular monthly periods? Y / N

Bleeding between periods? ___
Discharge? ___
Heavy Bleeding? ___
Bloating? ___ Gas? ___
Pain? ___ Headaches? ___
Low Back Pain? ___
Cramping? ___

Depression? ___
Irritability? ___
Miscarriage? ___ How Many?_________
No. of children born alive?__________
No. of stillbirths? ________
Complications with pregnancy? _____
No. of stillbirths? ________

Used birth control? _____
Dates______________
How many days cycle? _____
How many days flow? ______
Clotting? ___
Dark purple blood? ___
Brownish Blood? ___

**Are you or do you suspect that you might be pregnant now? Yes / No If yes, how many months? __________**

**MEN ONLY** – Please check all that apply:

Loss of sexual activity? ___
Discharge from penis? ___

Treatment for genitals? ___
Hernia (rupture)? ___

Prostate trouble? ___
Òther? ______________________

**MEN AND WOMEN** – Please check all that apply:

Headaches? ___
Dizziness? ___
Ringing in the ears? ___
Convulsions? ___
Blurred vision? ___
Coughing / Wheezing? ___
Stuffy/Runny Nose? ___
Acid Reflux / Heartburn? ___
Bad taste in mouth? ___
Loss of appetite? ___
Bleeding gums? ___
Sore throat? ___
Sweating other than with exertion? ___

Chest tightness? ___
Shortness of Breath? ___
Palpitations (feeling heartbeat?) ___
Pain in calves when walking? ___
Tingling in legs at night? ___
Trouble sleeping? ___
Anxiety-filled dreams? ___
Difficult or frequent urination? ___
Blood in urine? ___
Kidney stones? ___
Pain in abdomen? ___
Constipation? ___
Diarrhea? ___

Undigested food in stool? ___
Mucous in stool? ___
Fatigue? ___
Excessive Thirst? ___
Low Thirst? ___
Excessive Appetite? ___
Low Appetite? ___
Recent Weight Gain? ___
Recent Weight Loss? ___
Low Back Pain? ___
Knee Pain? ___
Cold Hands & Feet? ___
Numbness? Where?___________

Do you exercise regularly? Y / N How often (Hours/Days per week)___________
What type of exercise do you perform? ____________________________________________
Please describe any injuries: