NEW PATIENT FORM

Important: The information below is just one of the invaluable tools to be able to tailor an effective treatment to you. You are unique, your health concerns are unique, so the more information that you provide, the quicker an effective tailor-made treatment can be developed for you. Some of the questions that follow may seem unrelated to your condition, but Oriental Medicine doesn't see you as your disease or your symptoms. We see you as a whole person, a kaleidoscope of interactions that are causing your symptoms. In order to be your health detective this information play's a major role in developing a diagnosis and treatment plan that will have an effective outcome in the shortest time possible. Every detail about your past and present state of health is important to us. Take time to think about the questions. Don't rush it just to get done. There are no wrong or right answers and no reason to be embarrassed. Just be honest. Your symptoms are a bit like a puzzle, we need all the pieces to complete your puzzle ☺

All information is strictly confidential.

1.) GENERAL PATIENT INFORMATION

Todays date_____

Full legal name (first, middle, last): _____

What name do you go by? (if different from above):_____

Age: ____ Date of birth:_____ Gender: M / F Height:_____ Weight: _____

Street address:_____

City:_____State:_____Zip:_____

Home phone#:_____Cell phone#:_____Work#:_____

Email:_____

Which do you prefer for confidential contact: ☐ Home# ☐ Cell# ☐ Work# ☐ Email

Emergency Contact: Name _____ Phone _____

Guardian (if under 18): _____

How did you hear about us?_____

Occupation: _____

Who is your current primary care doctor?_____Phone _____

Have you seen an acupuncturist before? ☐ Yes ☐ No

If yes, whom?_____when?_____for what?_____

Have you had imaging (MRI, CT, X-ray) for the condition we are treating? ☐ Yes ☐ No

Is your condition related to a motor vehicle accident? ☐ Yes ☐ No

Is your condition related to a work-related accident? ☐ Yes ☐ No

Do you have an open personal injury claim? ☐ Yes ☐No

Cancellation Policy:

If you need to change or cancel your appointment please do so with a minimum of 24 hours notice so that we can give the appointment to someone else who may needs immediate care. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

2.) HEALTH HISTORY

Please write your Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional:_____

When is the last time you felt well, healthy, vibrant and pain free?_____

Previous treatments for these complaints and did any of these treatments help? If so, circle the ones that did?

_____

_____

How was your childhood health? ☐Good ☐Average ☐Poor

Hospital Visits/Stays:_____

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ HIV/STD ☐ Pap smear ☐ Mammography ☐Blood(which?)_____

Other:_____

Test Results and Date:_____

List ant scars you have from cuts or surgeries: _____

_____

Check any of the following that you have had, or currently are experiencing:

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hypertension
- ☐ Fibromyalgia
- ☐ Epilepsy
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Spondylitis
- ☐ Rheum. Arthritis
- ☐ Osteoarthritis
- ☐ Scoliosis
- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia

Other(s):_____

List any **mental/psychological/psychiatric disorders** (with approx. dates):_____

_____

SURGICAL HISTORY

Please list any surgeries including reason and date:

Date:_____Procedure:_____Reason:_____

Date:_____Procedure:_____Reason:_____

Date:_____Procedure:_____Reason:_____

FAMILY HISTORY

- ☐ Diabetes
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Fibromyalgia
- ☐ Spondylitis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Scoliosis
- ☐ Epilepsy
- ☐ Stroke
- ☐ Heart disease
- ☐ Cancer

SOCIAL HISTORY

Do you currently smoke tobacco? ☐Yes ☐ No Have you ever smoked tobacco? ☐ Yes ☐ No

If yes, when did you quit: _____

Do you have any history of substance abuse? ☐ Yes ☐ No

If yes, please describe:_____

Please list significant life changes in the past 5 years (i.e. divorce, married, lost job, had a baby and so on)

_____

_____

Do you have any religion based dietary restrictions? (i.e vegetarian, Kosher etc) _____

Describe health of spouse:_____

Number of children:_____ Ages:_____Any physical conditions or concerns:_____

_____

MEDICATIONS & SUPPLEMENTS

Please include ALL prescription medications, supplements, herbal medicines, and OTC medicines along with dosage and brand if known. You may also provide your own list.

Drug/Supp:_____ Reason:_____Dosage:_____
Drug/Supp:_____ Reason:_____Dosage:_____
Drug/Supp:_____ Reason:_____Dosage:_____

TREATMENT PRECAUTIONS—YOU MUST SELECT ONE

It is important that you let us know if any of the following conditions currently apply to you. It is also important that you let us know if any of the following conditions becomes applicable during your course of treatment with us.

- ☐ Pacemaker
- ☐ Electrical implants
- ☐ Metal implants
- ☐ Bleeding disorders
- ☐ Taking blood thinners
- ☐ Pregnant
- ☐ Trying to get pregnant
- ☐ Breastfeeding
- ☐ Hepatitis A/B/C
- ☐ Epileptic
- ☐ Faint easily
- ☐ Food allergies
- ☐ Seizures
- ☐ None of these applies

PLEASE RATE YOUR ENERGY DURING THE DAY:

- ☐ Great, I have plenty of energy to get all my work done
- ☐ Good, I have enough energy to get through the day, but could use a little more
- ☐ Below average, it's a struggle for me to get through the day, but I get it done
- ☐ Poor, my energy levels are so low that its affecting my life and keeping me from getting things done……I really need help here

Is there anything else you would like us to know that you will feel is relevant to helping you get better?

3.) IF YOU EXPERIENCE PAIN – please complete this section

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Other:_____

- ☐ Cramping
- ☐ Dull
- ☐ Moving or radiating
- ☐ Fixed

What makes the pain feel better?

- ☐ Pressure
- ☐ Cold
- ☐ Other:_____

- ☐ Heat
- ☐ Exercise

What makes the pain feel worse?

- ☐ Pressure
- ☐ Stress/Emotions
- ☐ Other:_____

- ☐ Cold
- ☐ Heat

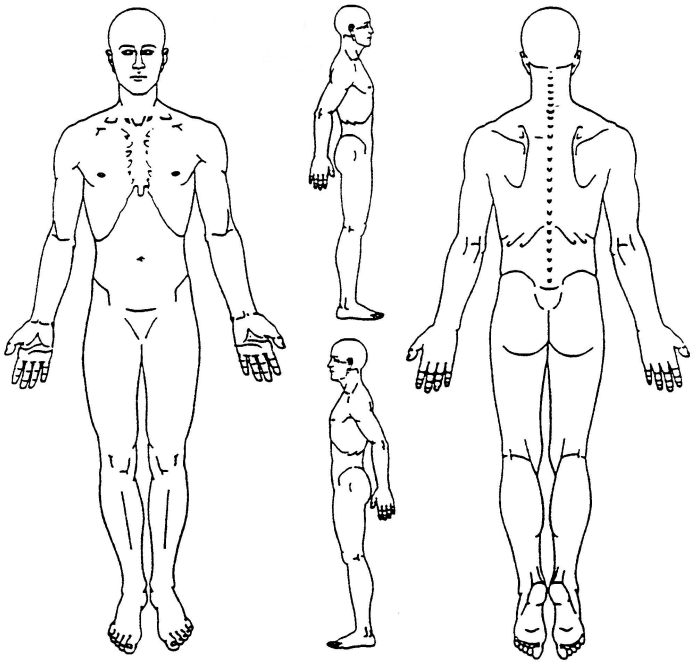
Does the pain affect you sleep? ☐Yes ☐ No

At which time of the day/night is the pain worse? _____

Since the pain began, do you have any areas that have: (if yes, please detail)

- ☐ Tingling _____
- ☐ Numbness _____
- ☐ Weakness_____

Please indicate where you have pain? (Please use a colored pen.)



X X X Sharp/Stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness
T T T Tightness/Spasms

On a scale of 1-10 (10 being the worst) what level is your pain right now

No Pain ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ **Need to go to ER**

What % of time are you generally at this level? _____%

When your pain is at its worst, what level of pain would it be at?

No Pain ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ **Need to go to ER**

What % of time are you generally at this level? _____%

How long have you been experiencing this pain?_____

4.) THE WHOLE PERSON APPROACH TO LOOKING AT YOUR SYMPTOMS

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates where we need to focus to restore function to your body). Some symptoms may be constant and some may come and go throughout the day or night or vary during the week.

Overall Temperature (Kidney function):

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temperature (sensation)
- ☐ Cold body temperature (sensation)
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet, and chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ No thirst
- ☐ Take water to bed because you wake up during the night to drink
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Tinnitus (high pitched ringing in ears)

Overall energy (Lung, Kidney function):

- ☐ Low energy
- ☐ Feel worse after exercise
- ☐ Shortness of breath
- ☐ Difficulty keeping eyes open in the daytime
- ☐ General weakness
- ☐ Easily catch colds

Overall blood (Liver, Spleen, Heart function):

- ☐ Dizziness
- ☐ See floating spots

Heart function:

How many hours sleep do you get on average per night?_____

- ☐ Difficult to fall asleep
- ☐ Difficult to stay asleep
- ☐ Frequent dreams
- ☐ Frequent nightmares
- ☐ Wake-up tired
- ☐ Wake-up rested
- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on the tip of the tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Drink caffeine beverage (# of cups per day: _____)

Lung function:

- ☐ Nasal Discharge (Color: _____)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Asthma
- ☐ RespiratoryAllergies (To what? _____)
- ☐ Alternating fever and chills
- ☐ Sneezing
- ☐ Headache (Location and feeling: _____)
- ☐ Overall achy feeling in the body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# of cigarettes per day: _____)
- ☐ Sadness
- ☐ Melancholy
- ☐ Sleep Apnea

Spleen function:

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Gurgling noise in the stomach
- ☐ Fatigue after eating
- ☐ Prolapsed organs (previously diagnosed, which organ? _____)
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-thinking
- ☐ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

- ☐ Loose
- ☐ Diarrhea
- ☐ Constipated
- ☐ Alternating diarrhea and constipation
- ☐ Irritable Bowel
- ☐ Incomplete
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stool

Dampness trapped in the body:

- ☐ General sensation of heaviness in the body
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

Stomach function:

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad breath
- ☐ Mouth (canker) sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer (diagnosed)
- ☐ Belching
- ☐ Hiccoughs
- ☐ Stomach pain
- ☐ Vomiting

Liver, Gall Bladder function:

- ☐ Alternating diarrhea and constipation
- ☐ Chest pain
- ☐ Tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Anger easily
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Frequently unable to adapt to stress (What causes the stress?_____)
- ☐ Skin rashes
- ☐ Headache at the top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck tension
- ☐ Limited Range-of-Motion, Neck
- ☐ Shoulder tension
- ☐ Limited Range-of-Motion, Shoulder
- ☐ Drink alcohol
- ☐ Recreational drugs (Which? _____, How much per week?___)
- ☐ Gall stones (history or current)
- ☐ Sexually transmitted disease(Which?_____)

Eyes (Liver function):

- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted

Kidney, Urinary Bladder function:

- ☐ Frequent cavities
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in the knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in the ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Wake during the night twice or more to urinate
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

Libido:

- ☐ Normal
- ☐ High
- ☐ Low

Urination:

- ☐ Normal color
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Strong odor
- ☐ Burning
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Painful
- ☐ Urgent
- ☐ Frequent
- ☐ Scanty
- ☐ Profuse

MEN ONLY:

☐Swollen testes ☐Testicular pain ☐Impotence ☐Premature ejaculation ☐Feeling of coldness or numbness in external genitalia ☐Other_____

WOMEN ONLY:

Regular menstrual cycle? ☐Y ☐N Pregnant? ☐Y ☐N

Number of children:_____ Number of pregnancies:_____

Age of first menstruation:_____ Age of menopause (if applicable):_____

Average number of days of flow:_____ Average number of days of entire cycle:_____

☐Vaginal discharge ☐Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

☐nausea ☐vomiting ☐water retention ☐breast swelling

☐food cravings ☐headaches ☐migraines ☐breast tenderness

☐depression ☐irritability ☐anxiety ☐other emotions:_____

☐dull pain, where?_____ ☐sharp pain, where?_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Applicable to everyone. All please fill out:

Other Comments:_____

_____

_____

Patient Signature Date

_____

Acupuncturist Signature Date

_____

Patient guardian signature (required if patient is under 18 years-old) Date