Patient Information

CONFIDENTIAL

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Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Clinic considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST)	DATE

AGE	DATE OF BIRTH	SEX	MARITAL STATUS
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PHONE	EMAIL ADDRESS

HOME ADDRESS		
CITY		ZIP

OCCUPATION	CELL PHONE

EMPLOYED BY		
REFERRED BY (Please write full name of referrer if possible) From Magazine / Homepage / word of mouth / internet search		

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE

ADDITIONAL INFORMATION/NOTES

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by ACURA Acupuncture Clinic is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor.

SIGNATURE _____ DATE _____

Medical History

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NAME (LAST, FIRST)

DATE

MAJOR COMPLAINT/HEALTH PROBLEM

HOW DID THIS CONDITION DEVELOP?

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? ☐ Yes ☐ No

IF YES, WHEN?

WHERE?

BY WHOM?

WHAT WAS THE DIAGNOSIS?

WHAT KIND(S) OF TREATMENT?

WHAT WERE THE RESULTS OF THE TREATMENT?

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG

LIST ANY MAJOR SURGERIES YOU HAVE HAD:

DATE	PROBLEM/SURGERY

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ AIDS
- ☐ Cancer
- ☐ Connective Tissue Disease
- ☐ Diabetes
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Stones
- ☐ Rheumatic Fever
- ☐ Ruptured Appendix
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Venereal Disease

Health History

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NAME (LAST, FIRST)	DATE

Please check any symptoms you currently have or have had in the past year.

General
☐ Chills
☐ Low energy
☐ Dizziness
☐ Allergies
☐ Fatigue
☐ Fevers
☐ Excess thirst
☐ Insomnia
☐ Nervousness
☐ Numbness
☐ Sweat spontaneously
☐ Night sweating
☐ Lack of sweating
☐ Weight loss
☐ Weight gain
☐ Aversion to heat
☐ Aversion to cold

Head & Neck
☐ Blurred vision
☐ Heaviness in the head
☐ Headache
☐ Phlegm in throat
☐ Cataract
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Eye pain/strain
☐ Corrected vision
☐ Nasal obstruction
☐ Nasal discharge
☐ Loss of sense of smell
☐ Hearing loss
☐ Hoarseness
☐ Nosebleeds
☐ Recurrent sore throat
☐ Red/inflamed eye
☐ Ringing in ears
☐ Sinus problems
☐ Sores on lips
☐ Sores on tongue
☐ Taste change
☐ Teeth problems
☐ Vision – see halos

Respiratory
☐ Asthma
☐ Hay fever
☐ Persistent cough
☐ Coughing blood
☐ Shortness of breath
☐ Recurrent bronchitis
☐ Phlegm production
☐ Difficulty inhaling
☐ Difficulty exhaling

Cardiovascular
☐ Chest pain
☐ High blood pressure
☐ Low blood pressure
☐ Irregular heart beat
☐ Poor circulation
☐ Swelling of ankles
☐ Varicose veins
☐ Hypochondriac pain
☐ Distention in chest or hypochondrium

Gastrointestinal
☐ Abdominal pain
☐ Bloating
☐ Belching
☐ Gas
☐ Constipation
☐ Diarrhea/loose stools
☐ Bloody stools
☐ Black stools
☐ Difficulty swallowing
☐ Poor appetite
☐ Heartburn/reflux
☐ Hemorrhoids
☐ Indigestion

☐ Stomachache
☐ Nausea
☐ Vomiting
☐ Vomiting blood

Diet/Lifestyle
☐ Vegetarian
☐ Healthy diet
☐ Eat much fried foods
☐ Eat much meat
☐ Smoke cigarettes
☐ Drink alcohol
☐ Drink coffee
☐ Use drugs
☐ Eat a lot of sweets
☐ Take melatonin
☐ Take steroids
☐ Exercise regularly
☐ Exercise excessively

Weight
☐ Underweight
☐ Normal for height
☐ Overweight
☐ Very overweight

Genitourinary
☐ Dilute urine
☐ Dark urine
☐ Blood in urine
☐ Cloudy urine
☐ Burning urination
☐ Scanty urine
☐ Profuse urine
☐ Frequent urination
☐ Poor bladder control
☐ Urgency to urinate

Musculoskeletal
Pain, weakness, numbness in:
☐ Arms
☐ Feet
☐ Hands
☐ Joints
☐ Legs
☐ Hips
☐ Neck
☐ Shoulders
☐ Pain all over
☐ Cold limbs
☐ Knee problems
☐ Low back pain
☐ All over weakness
☐ Lack of strength
☐ Broken bones

Skin
☐ Thick skin
☐ Thin skin
☐ Broken blood vessels
☐ Blood not clotting
☐ Bruise easily
☐ Discoloration
☐ Dark circles around eyes
☐ Bags under eyes
☐ Lumps in groin
☐ Lumps underarm
☐ Dry skin
☐ Acne
☐ Brittle nails
☐ Premature gray hair
☐ Dry, brittle hair
☐ Hair falling out

Neurologic
☐ Fainting
☐ Convulsions
☐ Handwriting change
☐ Paralysis
☐ Stroke
☐ Seizures
☐ Tremor
☐ Recent clumsiness
☐ Drowsiness
☐ Vertigo

Emotional
☐ Insomnia
☐ Irritability
☐ Often feel angry
☐ Troubling dreams
☐ Cry uncontrollably
☐ Feel sad a lot
☐ Forgetful
☐ Mind not clear
☐ Anxiety
☐ Much fear
☐ Unrestrained joy
☐ Terrors
☐ Difficulty expressing emotions

Men Only
☐ Genital pain
☐ Impotence
☐ Genital sores
☐ Lump in testicles
☐ Penis discharge
☐ Nocturnal emission
☐ Low sexual energy

Women Only
☐ Abnormal pap smear
☐ Bleed between periods
☐ Irregular periods
☐ Heavy periods
☐ <25 day cycle
☐ >35 day cycle
☐ Endometriosis
☐ Painful periods
☐ Premenstrual tension
☐ Breast lumps
☐ Contraceptives
☐ Sores on genitalia
☐ Low sexual energy
☐ Vaginal discharges
☐ Menopausal
☐ Uterine prolapse
☐ Facial hair
☐ Loss of head hair
☐ May be pregnant