Patient Information
(Please Print)

Patient's Name _____
(Last) (First) (MI)

Local Address _____ City _____State ____ Zip _____

Mailing Address (if different) _____

Home Phone (____) _____ Age _____ Date of Birth _____ Sex _____

Cell Phone (____) _____ Height _____ Weight _____

Marital Status _____Married _____ Divorced ____ Separated ____ Widowed ____ Minor _____

If Minor, Responsible Party_____

Out of State Address and Phone _____

Social Security # _____ Employer's Name _____

Employer's Address _____ City _____ State ____ Zip _____

Business Phone (____) _____ Occupation _____

Spouse's Name _____ Spouse's Employer _____

Employer's Address _____ City _____ State ____ Zip _____

Business Phone (____) _____ Occupation _____

Person to Notify in Case of Emergency, Other Than Spouse _____ Phone _____

Referred By _____

Family Physician _____ Phone _____Copy to Physician? ___ Yes ___ No

Medications 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Supplements 1) _____ 2) _____ 3) _____

Allergies 1) _____ 2) _____ 3) _____

Is This Related to an Automobile Accident? _____ is this a Worker's Comp Injury? _____

Please List Past Surgeries _____

Do you smoke? Yes _____ No _____ If Yes, How Much _____

Do you drink coffee/black tea? If Yes, How Much _____

Do you use alcohol? Yes ___ No ___ If Yes, How Much _____

Do you Exercise? Yes ___ No ___ If Yes, How Much _____

Major Complaint(s) in order of significance to you. Please rate each complaint on a scale of 1-10. 1 is virtually symptom-free and 10 unbearable.

1. **Major Complaint:** _____
2. Secondary Complaint: _____
3. Other Complaint: _____
4. Other Complaint: _____
5. Other Complaint: _____

Overall Energy (Lung, Kidney function):

- ☐Shortness of Breath
- ☐Difficulty keeping eyes open in the day time
- ☐Overall Weakness
- ☐Easily catch colds
- ☐Low Energy
- ☐Feel worse after exercise

Heart function:

- ☐Palpitations
- ☐Anxiety
- ☐Sores on the tip of the tongue
- ☐Lack of Taste
- ☐Mental confusion
- ☐Chest pain traveling to shoulder
- ☐Frequent dreams
- ☐Wake up tired
- ☐Insomnia
- ☐Mental sluggishness
- ☐Mental fogginess

Spleen function:

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

Lung function:

- ☐Nasal Discharge (Color: _____)
- ☐Cough
- ☐Nose Bleeds
- ☐Sinus Congestion
- ☐Dry Mouth
- ☐Dry Throat
- ☐Dry Nose
- ☐Dry Skin
- ☐Allergies (To What? _____)
- ☐Alternating chills and fever
- ☐Sneezing
- ☐Headache (Location: _____)
- ☐Overall achy feeling in body
- ☐Stiff neck
- ☐Stiff shoulders
- ☐Sore throat
- ☐Difficulty breathing
- ☐Sadness
- ☐Melancholy
- ☐Smoke cigarettes (# per day: _____)

Blood (Liver, Spleen, Heart functions):

- ☐Dizziness
- ☐See floating spots
- ☐Poor Memory
- ☐Pale Skin

Spleen, Stomach, Large Intestine, Small Intestine function:

- □Loose
- □Constipated
- □Incomplete
- □Diarrhea
- □Blood in stools
- □Mucous in stools
- □Undigested food in stools

Dampness:

- □Heavy sensation in body
- □Mental heaviness
- □Swollen hands
- □Swollen feet
- □Swollen joints
- □Chest congestion
- □Nausea
- □Snoring

Stomach function:

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

Liver, Gallbladder function:

- □Alternating diarrhea and constipation
- □Chest pain
- □Tight sensation in the chest
- □Bitter taste in the mouth
- □Anger easily
- □Frustration
- □Depression
- □Irritability
- □Frequent unable to adapt to stress
- □Skin rashes
- □Headache at 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 in shoulders
- □Drink alcohol
- □Recreation drugs? (which? _____)
  how much per week? _____
- □High-pitched ringing in ears
- □Gall-stones
- □Sexually transmitted disease (which? _____)

Kidney, 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 ears
- □Kidney stones
- □Bladder infections
- □Wake during the night to urinate (How many times? _____)
- □Lack of bladder control
- □Fear
- □Easily startled

Urination

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

Overall Temperature (Kidney function):

- □Cold hands
- □Cold feet
- □Sweaty hands
- □Sweaty feet
- □Heat in the hands, feet or chest
- □Hot flushes
- □Night sweats
- □Hot body temperature (sensation)
- □Cold body temperature (sensation)
- □Lack of perspiration
- □Perspire easily
- □Thirsty
- □Take water to bed
- □Difficulty keeping eyes open in the daytime

Eyes (Liver function)

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

Libido:

□ Normal □ High □Low

Women only:

Age of first menstruation? _____ Regular menstrual cycle? □ Yes □ No

Average number of days of flow: ____ Pregnant? □ Yes □ No

Number of children? _____ Number of pregnancies: _____

Age of menopause: _____

Vaginal discharge: □ Severe □ Moderate □ Slight □ Normal

Bleeding between periods: □ Severe □ Moderate □ Slight □ Normal

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

□Nausea	□Food Cravings	□Depression	□Vomiting
□Irritability	□Migraines	□Anxiety	□Water Retention
□Breast Swelling	□Breast Tenderness	□Headaches	

How do these conditions impair your daily activities? _____

_____

Please fill in the following menstrual chart:
(Put in a number and what color it is)

	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)							
Mood							
Breast tenderness, soreness							

Men only:

	Severe	Moderate	Slight	Normal
Swollen testes	□	□	□	□
Testicular pain	□	□	□	□
Impotence	□	□	□	□
Premature ejaculation	□	□	□	□
Feeling of coldness or numbness in external genitalia	□	□	□	□

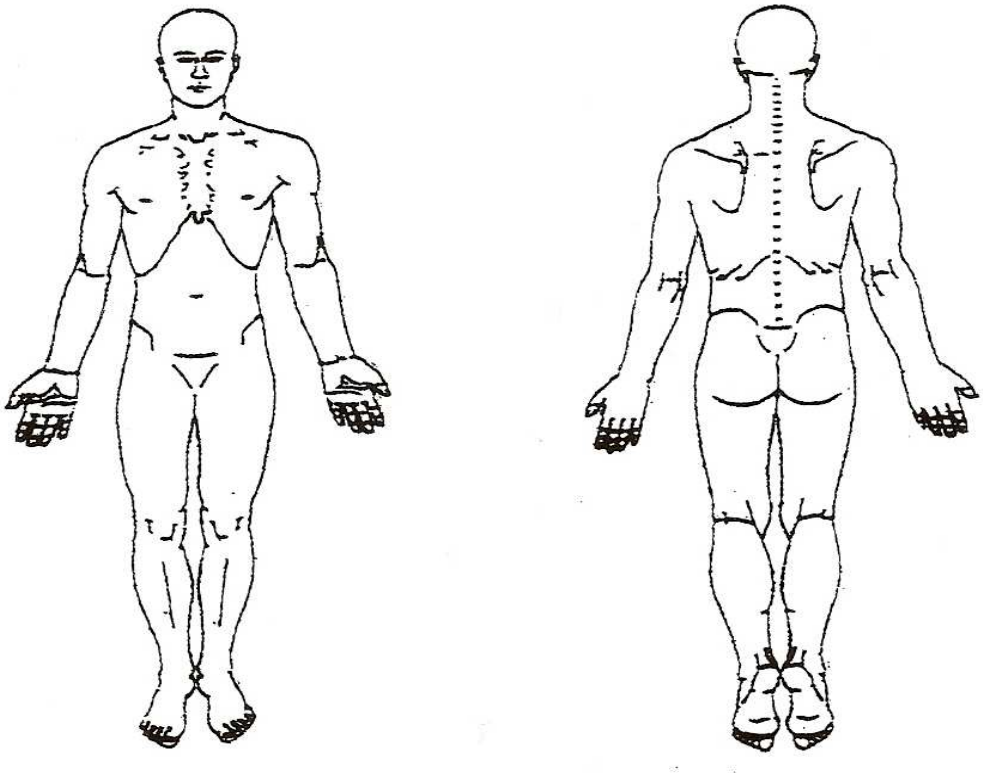
Other: _____

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

Is the pain:
□Sharp □Burning □Aching □Cramping □Dull □Moving □Fixed □Other: _____

Do the following lessen the pain?
□Pressure □Cold □Heat □Exercise □Other: _____

Do the following lessen the pain?
□Pressure □Cold □Heat □Exercise □Other: _____



Patient Medical History

How was your childhood health? _____
Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below)
□Physical □Cholesterol □Prostate □Blood □HIV/STD □Pap Smear
□Mammography □Other: _____

Test Results and Date: _____
_____

Check any you have had in the past:

□Rheumatic Fever	□Tuberculosis	□Glaucoma	□Diabetes
□Heart Disease	□CVA (stroke)	□Mumps	□Polio
□Chicken Pox	□Emphysema	□Cancer	□Allergies
□Vein Condition	□Bleeding Tendency	□HIV	□Mononucleosis
□Multiple Sclerosis	□Meningitis	□Asthma	□Nervous disorder
□Thyroid disorder	□Pneumonia	□Measles	□Gonorrhea
□Syphilis	□Jaundice	□Epilepsy	□Paralysis
□High Blood Pressure	□Hepatitis _____	□Migraines	□other liver illnesses
□other stomach illnesses	□other lung illnesses	□other kidney illnesses	□other heart illnesses
□other spleen illnesses	□other: _____		

Immunizations: _____

Surgeries (type and date): 1) _____ 2) _____
3) _____ 4) _____

Family History

Where are you in the birth order? □first □last □middle □ only

Check the following that have occurred in your blood relatives:

□Diabetes	□Cancer	□Heart Disease	□High Blood Pressure
□Tuberculosis	□Obesity	□Alcoholism	□Bleeding tendency
□Kidney Disease	□Allergies	□Stroke	□Mental Illness
□Nervous Illness	□ Other _____		

Please print the telephone number(s) where you want to receive calls about your appointments or other health care information: _____

(Check one)
_____ O.K. to leave messages with detailed information.
_____ Leave message with callback number only

Please print your e-mail address if you would like us to send a reminder of your appointment via the internet. _____

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY THE CLINIC IF THIS INFORMATION SHOULD CHANGE.