

Medical History Confidential

General Information

Patient Name _____ Date _____
Patient Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Gender: Male Female Age _____ DOB ___/___/___ SS# (opt.) _____
Marital Status _____ Weight _____ Occupation _____
Who is your medical doctor? _____ Date of last visit _____ Reason _____
Have you received acupuncture/Chinese herbs in the past? Yes No
Name of Acupuncturist _____ Date of last visit _____ Reason _____

Major Complaint

What is your primary reason for this visit?

This condition is due to: automobile work injury sports/exercise injury not sure
 illness other _____

What was the date of the injury/illness? _____ When did your symptoms begin? _____

Did your symptoms develop: gradually or suddenly How long do symptoms last? _____

Is there a pattern to when your symptoms occur? No Yes If yes, what is the pattern:

In the morning Occasionally During sleep
 In the evening Intermittently Upon awakening
 All day Constantly Other _____

What initiates your symptoms? _____

What makes them worse? _____ What makes them better? _____

Have you received treatment for this complaint? Yes No

If yes, what was done? _____

Did it help? Not at all Somewhat Very effective Not sure

Have any other family members had the same or similar complaint? Yes No

What was their treatment? _____

Did it help? Not at all Somewhat Very effective Not sure

Do you have specific questions you would like to discuss today? _____

Family History

Father Living - Age _____ Deceased - age at death _____ Cause _____
Mother Living - Age _____ Deceased - age at death _____ Cause _____
Other parent Living - Age _____ Deceased - age at death _____ Cause _____
Spouse Living - Age _____ Deceased - age at death _____ Cause _____
Siblings Gender _____ Health Status _____
Children Gender _____ Health Status _____

Check illness(es) which have occurred in any of your blood relatives:

Alcoholism Bleed easily Diabetes Heart disease Kidney disease Obesity
 Allergy Cancer Epilepsy High blood pressure Mental illness Stroke

Other: _____

Personal History

How would you describe your health as a child? _____

Check any illnesses or conditions you have or had in the past:

- | | | | | | |
|---|--|--|---|--|---|
| <input type="checkbox"/> AIDs/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High fevers | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Antibiotic use | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vascular disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | | |

Other: _____

List illnesses not requiring surgery for which you have been hospitalized:

List illnesses requiring surgery (including date):

List any other serious injury, broken bones, scars, etc.:

List allergies or sensitivity to any medicines or other substances:

Check the diseases against which you have been immunized:

- Diphtheria/Pertussis/Tetanus Tetanus only Measles/Mumps/Rubella Influenza
 Typhoid Hepatitis B Varicella (chicken pox) Other: _____

List date and results of last medical test:

Date	Test	Result	Date	Test	Result
	Physical			Stool	
	Cholesterol			HIV test	
	Hepatitis			PSA (prostate)	
	Mammography			Pap Smear	
	Other:			Other:	

Comments (anything else you would like to tell us):

I authorize treatment by a licensed acupuncturist. All information on this form is correct. I understand that I am responsible for payments of all fees to a treatment provider on the day of services are rendered unless other arrangements are made in advance.

Patient Signature _____

Date _____

Consent to treat a minor child
child (name) _____

Parent/Legal Guardian Signature _____

Date _____

Acupuncture therapist signature:
