Acupuncture & Herbal Medicine Clinic

Michelle D. Wu
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Patient Name _____ Male / Female Height _____ Weight _____

Date of Birth _____/_____/_____ Age ( ) Married___ Divorced___Single___Separated___Widowed___

Phone(C) _____ Phone(H) _____ E-mail _____

Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____ Phone (W) _____

Spouse's Name _____ Date of Birth _____/_____/_____

Employer _____ Phone (C) _____

Family Physician _____ Phone _____

Referred by _____

Please indicate who to notify in case of emergency

Name _____ Relationship_____ Phone _____

Name _____ Relationship_____ Phone _____

Insurance Information

Insurance Name_____ **2nd Insurance Name**_____

Subscriber's Name _____ **Subscriber's Name** _____

Date of Birth ____/____/_____ **Date of Birth** ____/____/_____

Relationship to Patient _____ **Relationship to Patient** _____

Do you have Medicare? [ ] Yes [ ] No

Was this a work related injury? [ ] Yes [ ] No

Was this injury related to a car accident? [] Yes [ ] No

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Patient's Name (Please print): _____ Date: _____

Chief Complaint(s) *Please indicate how long you've had the condition(s).*

Other Complaint(s) *Please indicate how long you've had the condition(s).*

What kinds of treatments have you received?

Are you allergic to any of the following? If yes, please specify)

( ) Medicine
( ) Food
( ) Herbs
( ) Others

Do you have or are you any of the following?

( ) Pregnant
( ) Cancer
( ) Pacemaker
( ) Electric Implants
( ) Metal Implants
( ) Epilepsy
( ) Severe Bleeding Disorders
( ) HIV/STD Positive
( ) Hepatitis A/B/C

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Confidential Patient Health History

Name: _____ **Date:** ___/___/___

List any Hospitalizations & Surgeries **Date** **Place**

_____
_____
_____
_____
_____
_____
_____
_____
_____

List medications being taken (include dose)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check if you have had (in the past three months):

General

[] Anemia
[] Fatigue
[] Wake Unrefreshed
[] Frequent Dreaming
[] Poor Sleep Habits
[] Insomnia
[] Difficult keep eyes open (Daytime)
[] Wake at night and Difficult to fall asleep
[] Fatigue after Eating
[] Snoring
[] Chest Congestion
[] Poor Appetite
[] Cravings
[] Always Hungry
[] Abrupt Weight Gain/Loss
[] High Cholesterol
[] Diabetes
[] Multiple Sclerosis
[] Thyroid problems
[] Peculiar Tastes or Smells
[] Difficulty Smelling
[] Sneezing
[] Swollen Hands/Feet
[] Swollen Joints
[] Tremors
[] Frequent cold/flu
[] Alcoholism
[] Drug Addiction
[] Poor Balance
[] Localized Weakness
[] Bleed or Bruise Easily
[] Alternating Chills & Fever
[] Fever
[] Chills
[] Sweats
[] Prolapsed Organ (which_____)
[] Muscle Cramping/Spasms

Skin and Hair

[] Rashes
[] Itching
[] Dandruff
[] Change in hair/skin texture
[] Ulcerations
[] Eczema
[] Open sore
[] Acne
[] Corns
[] Warts
[] Psoriasis
[] Recent moles
[] Loss of Hair
[] Hives
[] Nail Problems
[] Dry skin

Head, Eyes, Ears, Nose and Throat

[] Dizziness/Vertigo
[] Poor Hearing
[] Ringing in ears
[] Earaches
[] Grinding Teeth
[] Sinus Problems
[] Nose Bleeds
[] Nasal Congestion
[] Nasal Discharge (color_____)
[] Concussions
[] Migraines
[] Headaches (location_____)
[] Dry Throat
[] Hoarseness
[] Canker Sores (mouth)
[] Recurrent Sore Throats
[] Sores on Tip of the Tongue
[] Bleeding, Swollen or Painful gums
[] Eye Strain
[] Poor Vision
[] Blurry Vision
[] Night Blindness
[] Color Blindness
[] Eye Pain
[] Spots in front of eyes
[] Cataracts
[] Facial Pain

Cardiovascular

[] High Blood Pressure
[] Low Blood Pressure
[] Palpitations
[] Irregular Heartbeat
[] Mitral Stenosis
[] Mitral Prolapse
[] Phlebitis
[] Chest Pain Travel to Shoulder
[] Myocarditis
[] Pneumatic Heart Disease
[] Chest Pain
[] Varicose Veins
[] Swelling of Hands/Feet
[] Fainting
[] Perspire Easily
[] Difficulty in Breathing
[] Coronary Heart Disease
[] Hardening of Arteries
[] Blood Clots
[] Hot/Cold body Temperature
[] Sweaty hands/feet
[] Cold hands/feet
[] Heat in hands/feet

Respiratory

[] Cough
[] Bronchitis
[] Difficulty breathing lying down
[] Emphysema
[] Coughing Blood
[] Pneumonia
[] Asthma
[] Pain w/ deep breath
[] Production of Phlegm
[] Pleurisy

Gastrointestinal

[] Nausea
[] Vomiting
[] Bad Breath
[] Abdominal Pain or Cramps
[] Indigestion
[] Ulcer
[] Gas
[] Belching
[] Chronic Laxative Use
[] Rectal Pain
[] Loose Stools
[] Blood in Stools
[] Black Stools
[] Incomplete Stools
[] Mucous in Stools
[] Undigested Food in Stools
[] Burning Before/After Eating
[] Diarrhea
[] Constipation
[] Alternating Diarrhea or Constipation
[] Hemorrhoids
[] Acid Reflux
[] Abdominal Bloating
[] Colitis
[] Large Appetite

Genitourinary

[] Bed Wetting
[] Kidney Infections / Stones
[] Genital Herpes
[] Cystitis
[] Blood in Urine
[] Painful Urination
[] Venereal Disease
[] Incontinence
[] Frequent Urination
[] Bladder Infections
[] Prostate Problems

Pregnancy and Gynecology

[ ] Number of Pregnancies
[ ] Number of Abortions
[ ] Number of Births
[ ] Number of Miscarriages
[] Use of Birth Control
[] Clots
[] Hot Flash/Night Sweats
[] Osteoporosis
[ ] Age at 1st Menstruation
____ Time between Menstruation
____ Duration of Menstruation
____ First Date of Last Menstruation
[] Irregular Periods
[] Endometriosis
[] Frequent changes in emotion
[] Unusual Character (heavy/light)
[] Vaginal Sores
[] Vaginal Discharge
[] Breast Lumps
[] Painful Periods/Cramps
[] Uterine Fibroids

Musculoskeletal

[] Neck Pain
[] Back Pain
[] Hand/Wrist Pain
[] Muscle Pains
[] Muscle Weakness
[] Shoulder Pain
[] Knee Pain
[] Foot/Ankle Pain
[] Hip Pain

Neuropsychological

[] Seizures
[] Areas of Numbness
[] Concussion
[] Bad Temper
[] Difficulty Concentrating
[] Mental Confusion
[] Bodily Sensation of Heaviness
[] Dizziness
[] Lack of Coordination
[] Depression
[] Easily susceptible to stress
[] Overthinking
[] Overly Worried
[] Mental Heaviness
[] Loss of Balance
[] Poor Memory
[] Anxiety
[] ADD
[] Restlessness
[] Sadness
[] Mental Sluggishness

Infection

[] Measles
[] Rheumatic Fever
[] Malaria
[] Small Pox
[] Mumps
[] Tuberculosis
[] Chicken Pox
[] Whopping Cough
[] Typhoid Fever
[] Scarlet Fever

Social History

	No	**Yes**	**When Started**	**When Stopped**	**Amount**
Coffee	___	___	_____	_____	_____
Tea	___	___	_____	_____	_____
Alcohol	___	___	_____	_____	_____
Tobacco	___	___	_____	_____	_____
Other	___	___	_____	_____	_____

Family History (please include the relation)

[] Migraines _____
[] Heart Disease _____
[] Allergies _____
[] Asthma _____
[] Arthritis _____
[] Diabetes _____
[] Glaucoma _____
[] Stroke _____
[] High Blood Pressure _____
[] Mental Illness _____
[] Gall Stones _____
[] Cancer _____
[] Thyroid Disease _____
[] Epilepsy _____

Please tell us of any other problems you would like to discuss: