Confidential Patient Information Today's Date:

First Name:		Birthday:	Sex at Birth: M F O
Last Name:		Age:	Current Gender Identity:

Issue & Brief History: (please list in order of importance)	How long you have noticed?	Being Treated? And if so, by whom?
1.		❑ Yes ❑ No
2.		❑ Yes ❑ No
3.		❑ Yes ❑ No
4.		❑ Yes ❑ No

What do YOU think is causing your problem?	What are you hoping we will be able to do for you?
How would you know that your treatment is complete?	Have you had Acupuncture before? Yes No
	Chinese Herbal Medicine? Yes No

Review of Symptoms | Pain Presentation

Using the diagram below, mark areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also write notes next to your markings if a description would be helpful. Then, please answer the questions to the left by circling the number that best represents your pain, where 1 is no pain and 10 is the worst pain you can imagine.

Scars: Use the diagram to the right to draw any scars (major or minor) that you have.

Rate your pain by circling the one number that best describes your pain at its **WORST in the past 24 hours.**

1 2 3 4 5 6 7 8 9 10

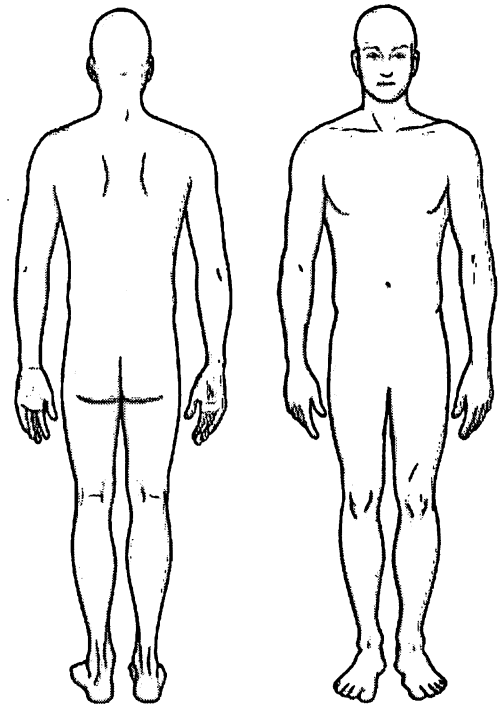
Rate your pain by circling the one number that best describes your pain at its **LEAST in the past 24 hours.**

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain on **AVERAGE for the past WEEK.**

1 2 3 4 5 6 7 8 9 10

Please note any joint replacements or prosthesis:



The pain is: ❑ sharp ❑ dull ❑ burning ❑ aching ❑ shooting ❑ numbing ❑ stabbing ❑ tingling ❑ comes & goes ❑ constant ❑ deep

With heat, pain is: ❑ worse ❑ better With cold, pain is: ❑ worse ❑ better

With pressure, pain is: ❑ worse ❑ better Pain worse in: ❑ AM ❑ PM

Are you currently taking pain medication? ❑ Yes ❑ No If yes, what medications?_____

How often do you take pain medications?_____ Does your pain disturb your sleep? ❑ Yes ❑ No

Genetic History | Do you, your partner, or anyone in your family have:

❑ Neural tube / spina bifida / anencephaly	❑ Huntington's	❑ Hemochromatosis
❑ Thalassemia	❑ Mental Retardation/Fragile X	❑ Sjogren's
❑ Down Syndrome	❑ Tay-Sachs	❑ Genetic/Inherited Disorder
❑ Cystic Fibrosis	❑ Sickle Cell disease or trait	❑ Chromosomal Disorder
❑ Muscular Dystrophy	❑ Hemophilia	❑ Baby with birth defects
❑ Factor V Leiden	❑ Hormonal Disorder	❑ Infertility

List any significant illnesses in your family:_____

Review of Symptoms

Medical History
- ☐ Cancer/Tumor
- ☐ Heart disease
- ☐ Diabetes
- ☐ Congestive heart failure
- ☐ Osteoporosis
- ☐ Autoimmune disease
- ☐ Lupus
- ☐ Rheumatic arthritis
- ☐ Arthritis
- ☐ Hypertension
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Gout
- ☐ Thyroid disease
- ☐ Depression
- ☐ Other mental illness
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Bleeding disorders
- ☐ Tuberculosis

Contagious Diseases
- ☐ HIV/AIDS
- ☐ Hepatitis C
- ☐ Hepatitis B

Respiratory
- ☐ Asthma
- ☐ Cough with blood
- ☐ Cough with phlegm
- ☐ Difficulty exhaling
- ☐ Difficulty inhaling
- ☐ Dry cough
- ☐ Allergies
- ☐ Recurrent bronchitis
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Tightness in chest

Cardiovascular
- ☐ History of heart attack
- ☐ History of blood clot
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ High cholesterol
- ☐ Heart palpitations
- ☐ Varicose veins
- ☐ Bruise easily
- ☐ Ankle swelling
- ☐ Leg Cramps
- ☐ Calf pain

Vitamin Levels
- ☐ Vitamin D (result & date)
- ☐ folate (result & date)
- ☐ B12 (result & date)
- ☐ Iron/ferritin (result & date)

Digestion
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty swallowing
- ☐ Heartburn/reflux
- ☐ Bitter taste in mouth
- ☐ Bad breath
- ☐ Ulcers
- ☐ Gallstones
- ☐ Liver disease

Urination
- ☐ Up at night to urinate
- ☐ Burning or painful
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Dribbling
- ☐ Urinary tract infections
- ☐ Poor bladder control
- ☐ Urgency
- ☐ Stones
- ☐ Kidney disease

Neurologic
- ☐ Seizures/Epilepsy
- ☐ Strokes
- ☐ Concussion
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Weakness
- ☐ Poor coordination
- ☐ Poor balance
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Vertigo
- ☐ Tremors

Mouth & Throat
- ☐ Dry mouth or throat
- ☐ Trouble swallowing
- ☐ Swollen glands
- ☐ Tooth problems
- ☐ Gum problems
- ☐ Mouth or tongue sores
- ☐ TMJ clicking or pain
- ☐ Teeth grinding or jaw clenching
- ☐ Drooling at night
- ☐ Dentures
- ☐ Hoarseness

Perspiration
- ☐ Very little or none
- ☐ Occurs without exertion
- ☐ Profuse
- ☐ Night sweats

Skin & Hair
- ☐ Dry
- ☐ Oily
- ☐ Rashes
- ☐ Itching
- ☐ Dark circles around eyes
- ☐ Pimples or acne
- ☐ Spider veins
- ☐ Eczema
- ☐ Psoriasis
- ☐ Brittle nails
- ☐ Prematurely grey hair
- ☐ Dry, brittle hair
- ☐ Hair falling out
- ☐ Dandruff

Eyes, Ears & Nose
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Wear glasses or contacts
- ☐ See spots in vision
- ☐ Poor night vision
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Painful or burning eyes
- ☐ Twitching eyelid(s)
- ☐ Light sensitive eyes
- ☐ Poor hearing
- ☐ Ear aches or infections
- ☐ Ringing (high pitched)
- ☐ Ringing (low pitched)
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Sinusitis

Pain
- ☐ Muscle cramps
- ☐ Muscle spasm
- ☐ Nerve problems
- ☐ Joint pain
- ☐ Stiffness
- ☐ Bone pain
- ☐ Fractures
- ☐ Dislocations

Bowel Habits
- ☐ Loose stool
- ☐ Diarrhea
- ☐ Hard or dry stool
- ☐ Mucus in stool
- ☐ Pain or cramps with BM
- ☐ Blood in stool
- ☐ Undigested food in stool
- ☐ Use laxatives often
- ☐ Hemorrhoids

How often do you have a bowel movement?____

Yes / No — Are you pregnant?

Yes / No — Do you have a pacemaker or ICD?

Emotions
- ☐ Often angry
- ☐ Difficult to express emotions
- ☐ Depressed
- ☐ Often worried
- ☐ Easily irritated
- ☐ Cry easily
- ☐ Stressed or anxious
- ☐ Forgetful
- ☐ Unrestrained joy
- ☐ Over-think everything
- ☐ Indecisive
- ☐ Hyper
- ☐ Restless
- ☐ Sad or grieving
- ☐ Fearful

Body Temperature
- ☐ Warm natured
- ☐ Flushed face or cheeks
- ☐ Warm in afternoon or evening
- ☐ Night sweats
- ☐ Cold natured
- ☐ Cold hands and feet

Males
- ☐ Prostate problems
- ☐ Impotence
- ☐ Low sex drive
- ☐ Penis discharge
- ☐ Genital sores

Females
- ☐ Spotting between periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ <25 day cycle
- ☐ >35 day cycle
- ☐ Vaginal discharge
- ☐ Endometriosis
- ☐ Painful periods
- ☐ PMS
- ☐ Breast lumps
- ☐ Low sex drive
- ☐ Uterine prolapse
- ☐ Facial hair
- ☐ Perimenopausal
- ☐ Menopausal

Thyroid
- ☐ TSH thyroid stimulating hormone (result & date)
- ☐ Free T3 (result & date)
- ☐ Free T4 (result & date)
- ☐ Reverse T3 (result & date)
- ☐ TPO/TGAB (for Hashimoto's) (result & date)

Have you ever experienced an emotional, spiritual or physical health incident from which you feel you have never recovered your previous level of health? Please discuss:

Surgeries/Hospitalizations | Please list any hospitalizations, surgeries, fractures, car accidents, or major trauma you have experienced:

❑ Appendectomy	❑ Biopsies	❑ Dental Surgery	❑ Gallstones	❑ Implants	❑ Other
❑ Arthroscopy	❑ Cholecystectomy	❑ Eye Surgery	❑ Hysterectomy	❑ Kidney Stones	
❑ Breast Implants	❑ C -Section	❑ Fracture	❑ Hernia	❑ Laparoscopy	

Briefly list details including date, outcome, etc:

Medications & Supplements | Please list any medications you are taking, or have taken, and for how long.

Medication	Reason for Taking	Date Started/Stopped	Dosage

Please list any medications you are allergic to:

Vitamin/Mineral/Supplement/Herbs	Reason for Taking	Date Started/Stopped	Dose (IU/mg)

Energy Level | List on a scale from 1 to 10 (10 being the highest) what your energy levels are during the following times:

Morning	1 2 3 4 5 6 7 8 9 10	Afternoon	1 2 3 4 5 6 7 8 9 10	Evening	1 2 3 4 5 6 7 8 9 10
Late Evening	1 2 3 4 5 6 7 8 9 10	After Meals	1 2 3 4 5 6 7 8 9 10	Overall	1 2 3 4 5 6 7 8 9 10

Stress Level | Rate your current stress level on a scale from 1 to 10 (10 being the highest):

Note that stress can come in forms such as overwork, relationships, health concerns, tiresome family or work responsibilities, trauma, excessive fear, worry, anxiety, insomnia, road rage, not happy with life, etc.

Current Stress Level: 1 2 3 4 5 6 7 8 9 10 Average Stress Level: 1 2 3 4 5 6 7 8 9 10

Main reasons for stress:

Dietary & Lifestyle Assessment | Please check the boxes in regards to how often you eat or drink the listed types of foods.

	More than Once Daily	Daily	3 Times Weekly	Once Weekly	Twice Monthly	Less or Never
Grains, Breads, Cereals	❑	❑	❑	❑	❑	❑
Milk & Dairy Products	❑	❑	❑	❑	❑	❑
Eggs	❑	❑	❑	❑	❑	❑
Meat, Poultry, Fish	❑	❑	❑	❑	❑	❑
Beans, Peas & Legumes	❑	❑	❑	❑	❑	❑
Fruits	❑	❑	❑	❑	❑	❑
Vegetables	❑	❑	❑	❑	❑	❑
Soy Products	❑	❑	❑	❑	❑	❑
Nuts & Seeds	❑	❑	❑	❑	❑	❑
Popcorn & Chips	❑	❑	❑	❑	❑	❑
Spicy Foods	❑	❑	❑	❑	❑	❑
Chocolate	❑	❑	❑	❑	❑	❑
Coffee	❑	❑	❑	❑	❑	❑
Tea	❑	❑	❑	❑	❑	❑
Alcohol	❑	❑	❑	❑	❑	❑
Soda	❑	❑	❑	❑	❑	❑
Fast Foods	❑	❑	❑	❑	❑	❑
Sugar & Sweets	❑	❑	❑	❑	❑	❑
Artificial Sweeteners	❑	❑	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑	❑	❑
Recreational drugs	❑	❑	❑	❑	❑	❑

List the **three unhealthiest foods** you eat during a typical week: 1._____ 2._____ 3._____

List the **three healthiest foods** you eat during a typical week: 1._____ 2._____ 3._____

Do you crave certain foods?_____

Do certain foods "disagree" with you? _____

Allergies or Sensitivities | Please list any known allergies, including food allergies, environmental, seasonal, etc.

Are you on a special diet? | Yes ☐ No ☐ | If yes, please check the appropriate boxes and explain in detail your dietary regimen

☐ Atkins	☐ Fruitarian	☐ Low Carb	☐ Pescatarian	☐ Vegetarian
☐ Blood Type Diet	☐ Gerson/Cancer Diet	☐ Low Fat	☐ Raw Food	☐ *Lacto (Dairy OK)*
☐ Dairy Restricted	☐ Gluten Restricted	☐ Low Sodium	☐ South Beach	☐ *Ovo (Eggs OK)*
☐ Diabetic	☐ Jenny Craig	☐ Macrobiotic	☐ Intermittent fasting	☐ *Ovo-Lacto (Eggs & Dairy OK)*
☐ Elimination Diet	☐ Ketogenic	☐ Mediterranean	☐ Vegan	☐ *Part Time*
☐ Food Combining	☐ Kosher	☐ Paleo	☐ Weight Watcher	☐ Other Diet:_____

Please tell us in a few words the reasons for your specific diet, the time duration you have been following the diet, and what results you have experienced by following this diet:

Exercise | Please check all boxes pertaining your exercise regimen and specify details if necessary:

Do you exercise? ☐ Yes ☐ No

If yes, what type of exercise?

☐ Walking	☐ Pilates	☐ Marathon (full / half / frequency per year:_____)
☐ Running	☐ Dance	☐ Martial Arts (please specify:_____)
☐ Weightlifting	☐ Yoga	☐ Team Sports (please specify:_____)
☐ Spinning	☐ Swimming	☐ Barre
☐ Biking	☐ Cross Fit	☐ Kettle Bell Training
☐ General Cardio	☐ Triathlon	☐ Other:_____

How often do you exercise? ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5 or more times per week

How long is your average exercise session? (circle one): 30min 60 min 90 min over 90 min

Do you train for any competition? If yes, please explain:_____

Sleep | Rate your sleep quality. Check all that apply:

☐ Restful sleep	☐ Wake up rested	☐ Nightmares	☐ Bruxing	☐ Other:_____
☐ Restless sleep	☐ Wake up tired	☐ Sleep Apnea	☐ Restless Legs	
☐ Difficulty falling asleep	☐ Vivid Dreams	☐ Snoring	☐ Wake up during the night (usual time of waking:_____)	

What time do you usually go to sleep? _____ How many hours do you sleep per night on average? _____

Thank you for providing such detailed information. Each piece you provide helps in better understanding the path you have been on up to the outset of your treatments. If there is anything you wish to bring to our attention which is not asked on this form, please note below: