

# Essence of China Acupuncture and Herb Clinic

## Patient Information Record

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_ Age \_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Office) \_\_\_\_\_ (Cell) \_\_\_\_\_

Occupation \_\_\_\_\_ Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_ Have you ever had Acupuncture before? \_\_\_\_\_

I desire for Essence of China personnel to provide me with the health therapies, which I have requested including Acupuncture, Chinese herbs, Cupping, and (or) Moxa. I do understand that this therapy may cause bruising, minor bleeding, and or redness. I realize that this therapy may be considered as an investigative procedure in the U.S. The duration of treatment varies person to person depending on his/her constitution and specific illness. I fully understand that there is no implied or stated guarantee of success or effectiveness after a specific treatment or a series of treatment. I acknowledge that the Traditional Chinese Medicine does not make a Western Medical diagnosis. I hereby certify that all information provided to you is true.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient's signature (Parent or guardian if under 18) \_\_\_\_\_ Date \_\_\_\_\_

Present Complaint \_\_\_\_\_  
\_\_\_\_\_

How long have you suffered this problem? \_\_\_\_\_

Have you been given a diagnosis for this problem? \_\_\_\_\_ If so, please describe \_\_\_\_\_  
\_\_\_\_\_

What medication are you currently taking? \_\_\_\_\_

### Past Medical History (Please include date):

Illness: \_\_\_\_\_

Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Significant trauma (Auto accident, falls, etc.): \_\_\_\_\_  
\_\_\_\_\_

Average of typical blood pressure \_\_\_/\_\_\_ Do you have pace maker or anything unusual in your body? \_\_\_\_\_

Do you have, or have you ever had, any infectious diseases? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

Medicines (prescription and over-the counter drugs, vitamins, herbs, etc) taken within last 3 months: \_\_\_\_\_  
\_\_\_\_\_

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### Family and Personal Medical History (General Health):

Mother's side: \_\_\_\_\_

Father's side: \_\_\_\_\_

If any of the above is disease, what was the cause? \_\_\_\_\_

Personal childhood health: \_\_\_\_\_

Current predominant emotion: \_\_\_\_\_

Do you have a regular exercise program? \_\_\_\_ Please describe: \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_ Please describe: \_\_\_\_\_

Do you have a normal appetite \_\_\_\_ If not, please describe: \_\_\_\_\_

Do you have a history of any the following?

<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease	<input type="checkbox"/> HIV	<input type="checkbox"/> Addictive disorders
<input type="checkbox"/> Seizures	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Mental illness

### Please check if you have experienced (in the last 3 months):

General:

<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Tremors	<input type="checkbox"/> Mania	<input type="checkbox"/> Headaches	<input type="checkbox"/> Poor balance
<input type="checkbox"/> Night perspiration	<input type="checkbox"/> Daytime perspiration	<input type="checkbox"/> insomnia	<input type="checkbox"/> Localized weakness
<input type="checkbox"/> Emotional changes	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Strong thirsty

Cardiovascular:

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Difficulty of breath
<input type="checkbox"/> Hypotension	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Cold hands or feet
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Swelling of hands or feet		

Respiratory:

<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> cough with phlegm
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Difficulty in breathing when lying down		

Gastrointestinal:

<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Bad breathe
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Belching
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Blood in stools

Genitor-Urinary:

<input type="checkbox"/> Painful urination	<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Stones in urinary system	<input type="checkbox"/> Waking up to urinate, how many times? ____	

Ear, Nose, Mouth, Throat and Eyes:

<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Pain in the ear	<input type="checkbox"/> Ear discharges
<input type="checkbox"/> Sinus problem	<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Gum bleeding	<input type="checkbox"/> Grinding teeth
<input type="checkbox"/> Jaw problem	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Facial pain
<input type="checkbox"/> Sores on lips or tongue	<input type="checkbox"/> Difficulty in swallowing	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Painful eyes
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Spots in front of eyes		

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**Musculoskeletal:**

General aches       Arthritis       Spasms       Recent sprains  
 Muscular atrophy       Muscular weakness       Muscle cramps

**Skin & Hair:**

Rashes       Ulceration       Acne       Eczema  
 Loss of hair      Any other hair or skin problems? \_\_\_\_\_

**Neuropsychology:**

Poor memory       Lack of coordination       Tingling of limbs       Area of numb  
 Depression       Easily angered       Anxiety       Stress

**Pregnancy & Gynecology:**

Age at first menses       Period between menses       Duration of menses  
 Irregular period       Clots       Heavy or light  
 Painful periods       Breast lumps       Vaginal discharge  
 Number of pregnancies       Number of births       Fertility problems  
 Miscarriages       Abortions       Last PAP smear  
 Birth control? How long? \_\_\_\_\_

Do you experience any change in body &/or psyche prior to menstruation? \_\_\_\_\_

Please tell us of any other problems you would like to discuss? \_\_\_\_\_

Please circle on the diagram any area pain or injury:

