A. CONFIDENTIAL PATIENT INFORMATION

date	**Full name**		**Preferred name**	
Address		**City**	**State**	**zip**
Home Phone		**Celle Phone**		
Driver's License #		**Social security #**		
Email -please print used for communication				
Gender	**Age**	**Date of Birth (MM/DD/YYYY)**	**Marital status**	
Emergency Contact name		**Relationship to Emergency contact**		
Emergency contact phone #		**Primary physician specialty**		
Primary Physician name		**Primary physician phone #**		
How did you hear about us?				
Preferred contact method from us	**Email**	**Phone call**	**Text message**	

INSURANCE INFORMATION

Primary Insurance	**Alternate Insurance**
Subscriber Name	**Subscriber name**
Group #	**Group #**
ID #	**ID #**
Date of Birth (MM/DD/YYYY)	**Date of Birth (MM/DD/YYYY)**
Relationship to subscriber	**Relationship to subscriber**
Cancellation Policy: I will give at least 24 hours' notice of cancellation. This can give the time to other patients who need the appointment. Initial_____	

B. MEDICAL HISTORY

Name:_____

Primary Complaint	**Aggravating/Relieving Factors**
Secondary complaint	**Aggravating/Relieving Factors**

****Please mark X if you have [ ]Pacemaker [ ]Implant foreign body [ ]Taking Blood Thinner**
[ ]Pregnant [ ]Restriction or Medical Condition [ ]Seizures

Allergy	**Medications**

Please mark X if applicable [ ]Addiction [ ]Smoking cigarette [ ]Cancer [ ]Hospitalization
[ ]Drinking Alcohol [ ]Sudden weight gain [ ]Sudden weight loss
[ ]Infectious Disease [ ]Smoke marijuana

****Do you have any medical conditions which need to be cautious when applying needles in your body parts?**
[ ]Yes ----- If Yes, please describe the detail: [ ]No

Past Medical History
Past Surgical History
Past trauma/accident/injury
Family History

Your life style Diet:
Exercise:
Stress level:

Feeling of Body temperature [ ]Hot [ ]Cold [ ]Normal [ ]Alternate Hot/Cold

General symptoms

[ ]Edema	**[ ]Bruises easily**	**[ ]Chills**
[ ]Fever	**[ ]Body Aches**	**[ ]Aversion to Wind**
[ ]Do not like Cold	**[ ]Do not like Heat**	**[ ]Strong Thirst**
[ ]Low thirst	**[ ]Poor Appetite**	**[ ]Night sweats**
[ ]Insomnia	**[ ]Fatigue**	**[ ]Nasal Congestion**
[ ]Foggy Headed	**[ ]Dizziness**	**[ ]Shortness of Breath**

Urination: **Bowel movement:**

C. CURENT HEALTH STATUS **Name: _____**

Neuro/pain

[ ]Dizziness [ ]Poor memory [ ]Loss of balance [ ]Migraine [ ]Irritability

[ ]Seizures [ ]Tremor [ ]Numbness/tingling [ ]Muscle weakness [ ]Muscle pain

[ ]Bone pain [ ]Neuralgia [ ]Muscle spasm [ ]Panic Attack [ ]Anxiety

[ ]Depression [ ]Fear [ ]Irritable [ ]Sadness [ ]Worry

[ ]Describe: _____

Head/Eyes/Ears/Nose/Throat

[ ]Dry eyes [ ]Red eyes [ ]Blurred vision [ ]Floaters [ ]Eye strain

[ ]Eye pain [ ]Watery eyes [ ]Heard of hearing [ ]difficult to focus [ ]Cataracts

[ ]Ear ringing: high pitch [ ]Ear ringing: low pitch [ ]Grinding teeth [ ]Toothache

[ ]Sinus issues [ ]Nose bleed [ ]Nose congestion [ ]Runny nose [ ]Facial pain

[ ]Ear pain [ ]Hoarse Voice [ ]TMJ [ ]Sore mouth [ ]Sore throat

[ ]Snoring [ ]Plum pit in throat [ ]Facial paralysis

Heart

[ ]Palpitation [ ]High blood pressure [ ]Low blood pressure [ ]irregular heart beat

[ ]Weight gain [ ]Cold hands/feet [ ] Cold hands/feet [ ]dizziness/vertigo [ ]Night sweat

[ ]Fainting [ ]difficulty fall asleep [ ]wake up often [ ]Chest pain [ ]Vein/artery issue

[ ]Others:_____

Respiratory

[ ]Dry cough [ ]Wet cough [ ]Bronchitis [ ]COPD [ ]Asthma

[ ]Phlegm [ ]Shortness of Breath [ ]Pain by deep breath[ ]Post nasal drip [ ]tight chest

[ ]Others:_____

Digestive

[ ]Constipation [ ]Diarrhea [ ]Abdominal pain [ ]Abdominal cramp [ ]Hiccups

[ ]Indigestion [ ]Acid regurgitation [ ]Nausea [ ]Bad breath [ ]Hemorrhoid

[ ]Bloating [ ]Fatigue [ ]Heavy limbs

[ ]Others:_____

Genito-Urinary **Name: _____**

[ ]Stones [ ]Frequent urination [ ]Painful urination [ ]Incomplete urination

[ ]Leaky urination [ ]Urgent urination [ ]Difficulty urination [ ]Incontinence

[ ]Prostate issue [ ]High Libido [ ]Low Libido [ ]UTI

[ ]Others:_____

Gynecological & obstetrics (women only)

[ ]Current pregnancy [ ]Irregular menses [ ]No menstruation [ ]Ovarian Cyst

[ ]Endometriosis [ ]Menstrual clots [ ]PMS [ ]PCOS

[ ]Uterine fibroid [ ]Pelvic Inflammatory [ ]Uterine fibroids [ ]frequent infection

[ ]Mid-cycle bleeding [ ]Others:_____

Musculo-Skeletal – check your painful area

[ ]Head [ ]Neck [ ]Shoulder [ ]upper back [ ]Mid-back [ ]Lower back

[ ]Ribs [ ]Wrist [ ]Elbow [ ]finger [ ]Hip [ ]Upper arm

[ ]Forearm [ ]Upper leg [ ]Lower leg [ ]Knee [ ]Ankle [ ]Foot

[ ]Toe [ ]Whole body [ ]Sacro-coccyx [ ]Upper Iliac Crest [ ]Weak muscle

[ ]Tight muscle [ ]Muscle pain [ ]Others: _____

Anything to know about your condition to achieve the effective treatment?

_____

_____

_____ _____