Essence of China Acupuncture and Herb Clinic
Patient Information Record

Name_____Date of Birth___/___/___ Sex___ Age_____

Address_____ City_____ State____ Zip_____

Phone: _____ (Home) _____(Office) _____(Cell)

Occupation_____Email Address_____

Emergency Contact_____ Relationship_____ 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 dates):

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 decease, 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?

___Cancer	___Asthma	___Diabetes	___ Thyroid disorders
___Allergies	___Heart disease	___HIV	___ Addictive disorders
___Seizures	___Hepatitis	___Stroke	___ Mental illness

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

General:

___Fevers	___Chills	___Fatigue	___Joint pain
___Tremors	___Mania	___Headaches	___Poor balance
___Night perspiration	___Daytime perspiration	___insomnia	___Localized weakness
___Emotional changes	___Weight loss	___Weight gain	___Strong thirsty

Cardiovascular:

___Hypertension	___Dizziness	___Fainting	___Difficulty of breath
___Hypotension	___Irregular heartbeat	___Palpitation	___Cold hands or feet
___Chest pain	___Swelling of hands or feet		

Respiratory:

___Cough	___Shortness of breath	___Coughing blood	___cough with phlegm
___Bronchitis	___Difficulty in breathing when lying down		

Gastrointestinal:

___Nausea	___Vomiting	___Ulcers	___Bad breathe
___Indigestion	___Abdominal pain	___Abdominal bloating	___Belching
___Constipation	___Diarrhea	___Hemorrhoids	___Blood in stools

Genitor-Urinary:

___Painful urination	___Unable to hold urine	___Urgent urination	___Frequent urination
___Blood in urine	___Stones in urinary system	___Waking up to urinate, how many times? ___	

Ear, Nose, Mouth, Throat and Eyes:

___Ringing in ear	___Poor hearing	___Pain in the ear	___Ear discharges
___Sinus problem	___Nasal obstruction	___Gum bleeding	___Grinding teeth
___Jaw problem	___Sore throat	___Hoarseness	___Facial pain
___Sores on lips or tongue	___Difficulty in swallowing	___Blurred vision	___Painful eyes
___Night blindness	___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? _____