PATIENT INFORMATION:
Pasaporte a la Salud

[ ] I Speak English [ ] I Speak Spanish [ ] I am Bilingual

Patient: [ ] Mr. Date: _____
[ ] Mrs.
[ ] Miss _____
first name middle name last name

yes no
[ ] male [ ] female [ ] [ ] ***are you, or might you be pregnant?*** height _____ weight _____

[ ] single [ ] married [ ] separated [ ] divorced [ ] widow/widower [ ] significant other

Date of birth: _____ Age: _____ Home phone: _____

Address:_____
street address city colonia state zip code

E-mail address: _____ Cellular phone:_____

Your employer: _____ Job title :_____

_____Work phone: _____
employer's street address city state

Spouse's name: _____
first name middle name last name

Spouse's employer: _____ Job title:_____

_____ Work Phone: _____
spouse's employer's street address city

Children: _____ Age: _____ Children: _____ Age: _____

Children: _____ Age: _____ Children: _____ Age: _____

Children: _____ Age: _____ Children: _____ Age: _____

If the patient is a minor or incapacitated, who is the legal guardian or representative accepting responsibility for care?

Name: _____ Phone: _____

_____
street address city state zip relationship

EMERGENCY CONTACT: Name of person not living with you:

_____
first name middle name last name

Address: _____
street address city state relationship

Home phone: _____ Work phone: _____

CURRENT COMPLAINTS, PROBLEM AREAS:

MAJOR COMPLAINT: Please list your problems beginning with the most severe problem first.

_____

_____

_____

Date of onset (when you first noticed the problem). _____

Describe your pain (circle a number): 0 1 2 3 4 5 6 7 8 9 10
No pain unbearable pain

Is your condition: [ ] getting worse [ ] constant [ ] comes and goes [ ] getting better

OTHER COMPLAINTS:

_____

_____

_____

_____

_____

Date of onset (when you first noticed the problem).____

Describe your pain (circle a number): 0 1 2 3 4 5 6 7 8 9 10
No pain unbearable pain

Is your condition: [ ] getting worse [ ] constant [ ] comes and goes [ ] getting better

Date of last physical exam? _____ Doctors name: _____

Are you being treated by a doctor now? [ ] yes [ ] no Diagnosis _____

THINGS TO BRING WITH YOU TO YOUR FIRST APPOINTMENT:

1. **This "Patient Information" form filled out in ink.**
2. **Bring X-rays, laboratory reports, blood tests, doctor's reports, etc.**
3. **Bring (in their original containers) all the medications you are currently taking.**
4. **Bring (in their original containers) all supplements, herbs, etc. you are currently taking.**

Who recommended you to our clinic:

[ ] spouse [ ] family [ ] friend [ ] co-worker [ ] doctor [ ] yellow pages [ ] advertisement [ ] other

Referred by: _____ _____
name phone

_____
address city state zip code

MEDICAL HISTORY

PATIENT SYMPTOM SURVEY: The information you provide is strictly confidential.

Please check any condition you ***Now*** have, or have had in the ***Past*** (more than 12 months)

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	diabetes	[ ]	[ ]	heart problems	[ ]	[ ]	liver disease
[ ]	[ ]	high blood pressure	[ ]	[ ]	stroke/CVA	[ ]	[ ]	kidney disease
[ ]	[ ]	low blood pressure	[ ]	[ ]	cardiac surgery	[ ]	[ ]	gallbladder disorder
[ ]	[ ]	bleeding disorders	[ ]	[ ]	pace maker	[ ]	[ ]	digestive disorder
[ ]	[ ]	cancer	[ ]	[ ]	organ transplant	[ ]	[ ]	artificial joints
[ ]	[ ]	lupus	[ ]	[ ]	arthritis/rheumatism	[ ]	[ ]	asthma/bronchitis
[ ]	[ ]	anemia	[ ]	[ ]	convulsions/seizures	[ ]	[ ]	ulcers
[ ]	[ ]	thyroid disorder	[ ]	[ ]	mental disorder	[ ]	[ ]	urinary bladder problem
[ ]	[ ]	weight gain	[ ]	[ ]	paralysis	[ ]	[ ]	chronic fatigue
[ ]	[ ]	weight loss	[ ]	[ ]	tremors	[ ]	[ ]	fainting spells
[ ]	[ ]	emphysema	[ ]	[ ]	tuberculosis	[ ]	[ ]	embolism
[ ]	[ ]	osteoporosis	[ ]	[ ]	prostate disorder	[ ]	[ ]	sexually transmitted disease

[ ] [ ] other: _____

_____

Yes No

Family History: Has any member of your family had any of the above conditions? [ ] [ ] if so which family member and what did they have?

_____

_____

_____

ACCIDENTS, FALLS, BROKEN BONES: Have you ever been in an auto accident, fallen down and/or broken bones or other traumas resulting in injuries? Please list date and occurrence beginning with the most recent experience.

_____

_____

_____

SURGERIES, MEDICAL PROCEDURES: Please list them, and the dates beginning with the most recent occurrence. Have you been advised to have any surgical procedure which has not been done? Yes [ ] No [ ]

_____

_____

_____

MEDICATIONS, DRUGS, HERBS & SUPPLEMENTS: Please list the name, dosage and the condition for which you are taking these drugs, such as; oral contraceptives, sleeping pills, relaxants, antidepressants, antibiotics, blood pressure, heart, thyroid, or ulcer medications or any other medications. Are you allergic to any medications? Yes [ ] No [ ]

_____

_____

_____

_____

EXTERNAL/SKELETAL EXAM:

HEAD:

Now Past

[ ] [ ] headache
- [ ] entire head
- [ ] back of head
- [ ] forehead
- [ ] temples

[ ] [ ] loss of taste
[ ] [ ] false teeth/dentures
[ ] [ ] migraine
- [ ] aura/specks of light
- [ ] aversion to light
- [ ] aversion to noise
- [ ] nausea/vomiting

[ ] [ ] dizziness/vertigo
[ ] [ ] dental problems
[ ] [ ] head feels heavy
[ ] [ ] light-headedness
[ ] [ ] memory loss
[ ] [ ] fainting
[ ] [ ] loss of balance
[ ] [ ] TMJ problems
[ ] [ ] gum disease

[ ] [ ] other: _____

_____

EYES:

Now Past

[ ] [ ] eye pain
[ ] [ ] blurred vision
[ ] [ ] wear glasses/contacts
[ ] [ ] dry eyes
[ ] [ ] tearing
[ ] [ ] other:_____
[ ] [ ] glaucoma
[ ] [ ] light bothers eyes

_____

date of last eye exam: _____

NOSE:

Now Past

[ ] [ ] sinus trouble
[ ] [ ] loss of smell
[ ] [ ] frequent nosebleeds
[ ] [ ] other: _____
[ ] [ ] frequent colds

_____

EARS:

Now Past

[ ] [ ] earache
[ ] [ ] poor hearing
[ ] [ ] other: _____
[ ] [ ] ringing/buzzing in ears
[ ] [ ] use hearing aid
[ ] [ ] ear discharge

_____

NECK/THROAT:

Now Past

[ ] [ ] pain in neck
[ ] [ ] stiff neck
[ ] [ ] popping sounds
[ ] [ ] teeth/gum problems
[ ] [ ] enlarged thyroid
[ ] [ ] other: _____
[ ] [ ] whiplash injury
[ ] [ ] herniated disc
[ ] [ ] difficulty swallowing
[ ] [ ] sleep on your stomach
[ ] [ ] swollen glands
[ ] [ ] sore throat
[ ] [ ] hoarseness
[ ] [ ] jaw problems
[ ] [ ] tight jaw
[ ] [ ] neck surgery

_____

SHOULDERS:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	pain in shoulder joint	[ ]	[ ]	pain across shoulders	[ ]	[ ]	tension in shoulder
[ ]	[ ]	can't raise arm:	[ ]	[ ]	muscle spasm in shoulders	[ ]	[ ]	problem is in:
		[ ] above shoulder	[ ]	[ ]	tendonitis/bursitis			[ ] right shoulder
		[ ] over head						[ ] left shoulder
[ ]	[ ]	other: _____						

_____

ARMS, ELBOWS, WRISTS & HANDS: Please circle "R" (right) or "L" (left)

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	pain in upper arm R/L	[ ]	[ ]	pain in elbow R/L	[ ]	[ ]	pain in hands R/L
[ ]	[ ]	pain in lower arm R/L	[ ]	[ ]	pain in wrist R/L	[ ]	[ ]	pain in fingers R/L
[ ]	[ ]	numbness R/L	[ ]	[ ]	pins & needles sensation R/L	[ ]	[ ]	cold hands R/L
[ ]	[ ]	loss of grip strength R/L	[ ]	[ ]	carpel tunnel syndrome R/L	[ ]	[ ]	hot hands R/L
[ ]	[ ]	other: _____						

_____

BACK:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	upper back pain	[ ]	[ ]	mid back pain	[ ]	[ ]	low back pain
		[ ] between shoulders			[ ] sharp stabbing pain			[ ] herniated disc
		[ ] muscle spasms			[ ] muscle spasms			[ ] muscle spasms
		[ ] pain is severe			[ ] pain is severe			[ ] sciatic nerve
[ ]	[ ]	other: _____						

_____

CHEST:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	chest pain	[ ]	[ ]	pain around ribs	[ ]	[ ]	persistent cough
[ ]	[ ]	shortness of breath	[ ]	[ ]	pain/pressure in chest	[ ]	[ ]	coughing phlegm
[ ]	[ ]	hard to breath	[ ]	[ ]	palpitations/tachycardia	[ ]	[ ]	coughing blood
[ ]	[ ]	wheezing	[ ]	[ ]	trouble breathing at night			[ ] phlegm color _____
[ ]	[ ]	other: _____						

_____

HIPS:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	hip pain R/L	[ ]	[ ]	pain in buttock R/L	[ ]	[ ]	joint replacement
[ ]	[ ]	sciatic pain R/L	[ ]	[ ]	numbness in hip/buttock R/L	[ ]	[ ]	stabbing pain R/L
[ ]	[ ]	other: _____						

_____

LEGS & KNEES:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	pain in upper leg R/L	[ ]	[ ]	pain in lower leg R/L	[ ]	[ ]	pain in knee
[ ]	[ ]	numbness/tingling R/L	[ ]	[ ]	numbness/tingling R/L			[ ] right knee
[ ]	[ ]	cramping R/L	[ ]	[ ]	cramping lower leg R/L			[ ] left knee
[ ]	[ ]	other: _____						

_____

ANKLES, FEET & TOES:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	ankle pain R/L	[ ]	[ ]	foot pain R/L	[ ]	[ ]	toe pain R/L
[ ]	[ ]	numbness at ankles R/L	[ ]	[ ]	numbness in feet R/L	[ ]	[ ]	numbness at toes
[ ]	[ ]	swollen ankle R/L	[ ]	[ ]	swollen feet R/L	[ ]	[ ]	swollen toes R/L
[ ]	[ ]	sprained ankle R/L	[ ]	[ ]	hot/cold feet R/L	[ ]	[ ]	hot/cold toes R/L
[ ]	[ ]	other: _____						

INTERNAL/ORGAN EXAM:

LUNGS/HEART:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	hard to breath	[ ]	[ ]	chest pain	[ ]	[ ]	ankle swelling
[ ]	[ ]	persistent cough	[ ]	[ ]	high blood pressure	[ ]	[ ]	varicose veins
[ ]	[ ]	coughing phlegm	[ ]	[ ]	low blood pressure	[ ]	[ ]	pace maker
[ ]	[ ]	coughing blood	[ ]	[ ]	tachycardia/irregular beat	[ ]	[ ]	angioplasty
[ ]	[ ]	other: _____						

LIVER & GALLBLADDER:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	hepatitis, type _____	[ ]	[ ]	high cholesterol	[ ]	[ ]	gall stones
[ ]	[ ]	sclerosis	[ ]	[ ]	high triglycerides	[ ]	[ ]	gallbladder surgery
[ ]	[ ]	other: _____						

KIDNEY & URINARY BLADDER:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	kidney infections	[ ]	[ ]	frequent bladder infections	[ ]	[ ]	painful urination
[ ]	[ ]	kidney stones	[ ]	[ ]	incontinence	[ ]	[ ]	frequent urination
[ ]	[ ]	water retention	[ ]	[ ]	blood in urine	[ ]	[ ]	excessive thirst
[ ]	[ ]	bed wetting	[ ]	[ ]	bad odor in urine	[ ]	[ ]	hard to urinate
[ ]	[ ]	kidney disorder	[ ]	[ ]	bladder disorder	[ ]	[ ]	dialysis program
[ ]	[ ]	loss of urine w/ cough	[ ]	[ ]	difficult start/stop urination	[ ]	[ ]	
[ ]	[ ]	other: _____						

STOMACH, DIGESTION & APPETITE:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	heartburn	[ ]	[ ]	nausea/vomiting	[ ]	[ ]	excessive appetite
[ ]	[ ]	stomach pain	[ ]	[ ]	stomach cramps	[ ]	[ ]	poor appetite
[ ]	[ ]	gastritis	[ ]	[ ]	abdominal bloating	[ ]	[ ]	appetite changes
[ ]	[ ]	bad breath	[ ]	[ ]	bitter/sour taste in mouth	[ ]	[ ]	food allergies
[ ]	[ ]	other: _____						

SMALL INTESTINE, LARGE INTESTINE & RECTUM:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	indigestion	[ ]	[ ]	constipation	[ ]	[ ]	hemorrhoids
[ ]	[ ]	parasites	[ ]	[ ]	diarrhea	[ ]	[ ]	painful evacuation
[ ]	[ ]	diverticulitis	[ ]	[ ]	colitis	[ ]	[ ]	bloody stool
[ ]	[ ]	abdominal pain	[ ]	[ ]	irritable bowel	[ ]	[ ]	mucus in the stool
[ ]	[ ]	lower bowel gas	[ ]	[ ]	stool has foul odor	[ ]	[ ]	black stool

[ ] [ ] other: _____

_____

[ ] What color is your stool: _____ [ ] How often do you have a bowel movement: _____

MALE REPRODUCTIVE SYSTEM:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	prostrate problems	[ ]	[ ]	erectile dysfunction	[ ]	[ ]	painful urination
[ ]	[ ]	dribbling after urination	[ ]	[ ]	low sex drive	[ ]	[ ]	unusual discharge
[ ]	[ ]	prostrate surgery	[ ]	[ ]	impotence	[ ]	[ ]	genital infections
[ ]	[ ]	premature ejaculation	[ ]	[ ]	sexually transmitted disease	[ ]	[ ]	HIV/AIDS

[ ] [ ] other: _____

_____

FEMALE REPRODUCTIVE SYSTEM:

Are you pregnant now? Yes [ ] No [ ] **Are you breast feeding now?** Yes [ ] No [ ]

First day of last period: _____ Last mammogram: _____

last OB/GYN exam: _____ Doctor: _____

Age started menstrual cycle: _____ Age stopped: _____

No. days bleeding: _____ color of blood: [ ] bright red [ ] dark red [ ] light red (watery)

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	menstrual pain	[ ]	[ ]	heavy bleeding	[ ]	[ ]	regular cycle
[ ]	[ ]	clotting	[ ]	[ ]	light/scanty bleeding	[ ]	[ ]	irregular cycle
[ ]	[ ]	painful breasts	[ ]	[ ]	mood changes	[ ]	[ ]	skip periods
[ ]	[ ]	head ache pain	[ ]	[ ]	water retention	[ ]	[ ]	hot flashes
[ ]	[ ]	low back pain	[ ]	[ ]	angry/emotional	[ ]	[ ]	food cravings
[ ]	[ ]	low sex drive	[ ]	[ ]	sexually transmitted disease	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	breast lumps/cysts	[ ]	[ ]	uterine cysts/tumors	[ ]	[ ]	painful ovaries
[ ]	[ ]	fibrocystic breasts	[ ]	[ ]	menopausal	[ ]	[ ]	hormone therapy
[ ]	[ ]	painful intercourse	[ ]	[ ]	endometriosis	[ ]	[ ]	fibrocystic breasts
[ ]	[ ]	pre-menopausal	[ ]	[ ]	cysts on ovaries or uterus	[ ]	[ ]	genital infections

[ ] [ ] vaginal discharge: [ ] white [ ] yellow [ ] thick [ ] watery [ ] odor [ ] itching

No. pregnancies_____ No. deliveries_____ No. miscarriages_____ No. abortions_____ No. cesareans _____

Operations: [ ] cervix [ ] uterus [ ] ovaries birth control: [ ] pills [ ] surgery

[ ] [ ] other: _____

_____

MENTAL EMOTIONAL & NEUROLOGICAL:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	nervous	[ ]	[ ]	easily angered	[ ]	[ ]	poor concentration
[ ]	[ ]	depressed	[ ]	[ ]	mood swings	[ ]	[ ]	mental confusion
[ ]	[ ]	worry/anxiety	[ ]	[ ]	frequent crying	[ ]	[ ]	poor coordination
[ ]	[ ]	suicidal	[ ]	[ ]	neuralgia (nerve pain)	[ ]	[ ]	tremors
[ ]	[ ]	grief/grieving	[ ]	[ ]	fear/fearful	[ ]	[ ]	indecision
[ ]	[ ]	sleep problems	[ ]	[ ]	hot/cold intolerance	[ ]	[ ]	chronic fatigue
[ ]	[ ]	numbness	[ ]	[ ]	pins/needles sensation	[ ]	[ ]	irritable/tension
[ ]	[ ]	paralysis	[ ]	[ ]	cramps/spasms	[ ]	[ ]	tick/twitches
[ ]	[ ]	mental disorder	[ ]	[ ]	nervous breakdown	[ ]	[ ]	bipolar disorder

[ ] [ ] sleep problems: [ ] trouble falling asleep [ ] trouble staying asleep [ ] restful
[ ] Wake up from sleep short of breath [ ] snore [ ] excess dreaming
[ ] wake up tired [ ] wake up refreshed How many hours do you sleep? _____

[ ] stress level: _____ 0 1 2 3 4 5 6 7 8 9 10 _____
No stress unbearable stress

What causes stress? _____

Now Past
[ ] [ ] Addiction to: [ ] alcohol [ ] tobacco [ ] recreational drugs [ ] medications

[ ] [ ] other: _____

_____

SKIN & SWEATING:

Now	Past		Now	Past		Now	Past	
[ ]	[ ]	dry	[ ]	[ ]	acne	[ ]	[ ]	night sweats
[ ]	[ ]	itchy	[ ]	[ ]	boils	[ ]	[ ]	excess sweating
[ ]	[ ]	moist/clammy	[ ]	[ ]	skin rash	[ ]	[ ]	rarely sweat
[ ]	[ ]	burning	[ ]	[ ]	hives/eczema	[ ]	[ ]	changing moles
[ ]	[ ]	lumps/tumors/cysts	[ ]	[ ]	shingles	[ ]	[ ]	dry scalp
[ ]	[ ]	varicose veins	[ ]	[ ]	bruises easily (black & blue)	[ ]	[ ]	hair loss
[ ]	[ ]	fever/chills	[ ]	[ ]	inflammation	[ ]	[ ]	edema

[ ] [ ] other: _____

_____

NUTRITION & LIFESTYLE:

Do you eat [ ] breakfast [ ] lunch [ ] dinner [ ] snack between meals

No. glasses consumed daily: [ ] water _____ [ ] coffee _____ [ ] cola _____ [ ] milk _____

Other beverage: _____

Do you use alcohol: [ ] yes [ ] no amount per week _____ type _____

Do you use tobacco [ ] yes [ ] no packs per day _____ No. years _____

Do you plan your meals using the four basic food groups? [ ] yes [ ] no

Eat raw fruits or vegetables at least twice a day? [ ] yes [ ] no

Eat yellow or green vegetables at least twice a day? [ ] yes [ ] no

Do you chew your food thoroughly before swallowing? [ ] yes [ ] no

Do you chew gum regularly/often [ ] yes [ ] no

Do you eat frequently between meals [ ] yes [ ] no

Do you eat meat and/or dairy products two or more times per day? [ ] yes [ ] no

Do you exercise for 30 minutes per day, 4 days per week, or more? [ ] yes [ ] no

Do you take vitamins, minerals or other supplements? [ ] yes [ ] no

Often people have concerns about their health but are too embarrassed or afraid to ask.

Do you have any questions or concerns about [ ] cancer [ ] heart disease [ ] addictions
[ ] sexual issues or dysfunction

[ ] other: _____

_____

What are your main health and personal goals at this time? _____

_____

_____

_____

How do you feel about the following areas of your life: Please check the box that applies.

	Great	Good	Fair	Poor	Bad	Comments
Spouse/Significant other	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Family/home life	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Diet	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Exercise	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Sex	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Self	[ ]	[ ]	[ ]	[ ]	[ ]	_____
Occupation/Work	[ ]	[ ]	[ ]	[ ]	[ ]	_____

REQUEST FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible)

I understand the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Swedish massage, Chinese herbal medicine, and nutritional and lifestyle counseling.

I have been informed that acupuncture may have some side effects, including occasional bruising. Some bruising may also be a side effect of cupping. This clinic uses sterile one time use disposable needles

I will notify the acupuncturist who is caring for me if I am or become pregnant, have a change in my condition or medications or have any adverse reactions to treatments.

I understand the clinical and administrative staff may review my patient records, x-rays and lab reports, and that all my records will be kept confidential and will not be released without my written consent.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Date Signature of patient

_____

Patients guardian or representative

_____

Relationship