Acupuncture & homeopathy center

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Orlando, FL 32819
Phone: (407) 766-3702

Confidential Patient Information

PRINT

General Patient Information

Name____ Date______________

Address____

City___________________________ State________________ Zip________________

Social Security #__________________________ Date of Birth_______________________

Age________ Gender: Male______ Female______ Married________ Single___________

Home Phone: _________________Cell Phone: ________________ Work Phone: _________

E-mail address: _________________________

Place of Employment_________________________ Occupation ______________________

Emergency Contact_____________________________ Phone_______________________

How did you hear about us? Referred by____

Web-site______ Drive-by______ Other_______________________

Current Medications: ____

____

Current Supplements (vitamins, herbs, etc.):____

____

Major Complaint(s), in order of significance to you:

1. Major Complaint: ____

2. Secondary Complaint: ____

3. Other Complaint: ____

4. Other Complaint: ____

How do these conditions impair your daily activities? _________________________________

____

____

____

Patient Medical History

How was your childhood health? ____

Surgeries: 1.____________________ 2.__________________3.______________________

4. ____________________ 5.__________________6._____________________

Recent tests: (please bring the copy of those)

Physical Cholesterol Blood Prostate HIV STD Pap smears Mammography

Other ____

Check any you have had in the past:

○Diabetes	○Allergies	○ Glaucoma	○ Rheumatic Fever
○Heart Disease	○Thyroid Disorder	○ Asthma	○ Pneumonia
○CVA (stroke)	○Tuberculosis	○ Emphysema	○ Jaundice
○Vein Condition	○Gonorrhea	○ Mumps	○ Bleeding tendency
○ Syphilis	○ Measles	○ Chicken Pox	○ Nervous Disorder
○ Meningitis	○HIV	○ Polio	○ Mononucleosis
○ Epilepsy	○ Cancer	○ Hepatitis	○ Multiple Sclerosis
○ Paralysis	○Migraines	○ High Blood Pressure	○ other lung illness
○ other Liver illness	○ other kidney illness	○ other spleen illness	○ other stomach illness
○ other heart illness			

Other: ____

Accident injury: ____

Habits/ Excess usage

o Alcohol	o Chocolate	o Cigarretes	o Coffee	o Soda	o Drug	o Food
oExercise	o Salt	o Sugar	o Tea	o Sex	o Other ________	

Family Medical History

Check the following that have occurred in your blood relatives:

○ Diabetes	○ Cancer	○ Heart Disease	○ High Blood Pressure
○ Allergies	○ Tuberculosis	○ Obesity	○ Bleeding Tendency
○ Kidney Disease	○ Alcoholism	○ Nervous Illness	○ Mental Illness

○ Stroke ○Other____

Patient Profile

Please clearly mark any areas of pain on the diagram on the following page:

How your pain is ?
○ Sharp ○ Burning ○ Aching ○ Cramping ○ Dull ○ Moving ○ Fixed ○ Other:__________

What make your pain better?
○ Cold ○ Heat ○ Pressure ○ Exercise Other:
____

What make your pain worse?
○ Pressure ○ Cold ○ Heat ○ Exercise ○ Other _______________________

Please check any of the following that is related to you:

Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1 being minor, 10 being severe)

RIGHT LEFT RIGHT

Complaint Index

B Burning **S** Sharp/Stabbing
N Numbness/Tingling **A** Ache

For example: if you are experiencing moderately severe burning pain in back of your neck, you should note a "B8" on the neck of the illustration.

If this is an injury, describe what happened:
____
____
____
____

On a scale of 0-10, how do you feel now? (0 Being Fantastic, 10 Being Extremely Poor)

0 1 2 3 4 5 6 7 8 9 10

<u>Overall Temperature (Kidney function):</u>

○ Cold hands ○ Cold feet ○ Sweaty hands ○ Sweaty feet
○ Afternoon flushes ○ Hot flushes ○ Night sweats ○ Hot sensation
○ Cold sensation ○ Perspire easily ○ Lack of perspiration ○ Thirsty
○ Low energy ○vaginal dryness

<u>Eyes (Liver function):</u>

○ Itchy ○ Bloodshot ○ Hot ○ Dry
○ Watery ○ Pressure o Blurry vision ○ See floaters

<u>Overall Energy (Kidney, Spleen, Lung function):</u>

○ Easily catch colds ○ General weakness ○ Shortness of breath ○ Fatigue

<u>Blood (Liver Spleen, Heart function):</u>

○ dizziness ○ poor memory ○ pale skin ○ fatigue ○ graying hair

Heart function:

○ palpitations ○ anxiety ○ restlessness ○ sores on tongue
○ mental confusion ○ vivid dreams ○ chest pain ○ insomnia
○ mental fogginess ○ wake up tired ○ mental sluggishness

Lung function:

○ cough ○ sinus congestion ○ nose bleeds ○ dry mouth
○ dry throat ○ dry nose ○ dry skin ○ sneezing
○ body aches ○ stiff neck ○ stiff shoulders ○sore throat o Easy sweat
○ melancholy ○ chills & fever ○ difficult breathing
○ nasal discharge /color:____
○ allergies/to what:____
○ headache/location:____
○ smoke cigarettes/#per day:____

Spleen function:

○ low appetite ○ bloating ○ abrupt weight change ○ gas
○ gurgling stomach ○ easily bruise ○ fatigue after eating ○ hemorrhoids
○ over-thinking ○ worry ○ organ prolapsed ○ constipation
○ loose stools ○ diarrhea ○ mucous in stools
○ incomplete stools ○ undigested food in stools ○ blood in stools

Dampness:

○ swollen hands ○ swollen feet ○ swollen joints ○ chest congestion
○ nausea ○snoring ○ heavy body sensation ○ snoring

Stomach function:

○ burning ○ bad breath ○ very large appetite ○canker sores
○heartburn ○acid reflux ○ bleeding or swollen gums ○ulcer
○belching ○hiccups ○ stomach pain ○vomiting

Liver/Gallbladder function:

○ chest pain ○anger easily ○ tightness in chest ○ bitter taste
○ frustration ○depression ○ frequent headaches ○ irritability
○ tingling ○ numbness ○ muscles spasms ○ seizures
○ twitching ○ convulsions ○ lump in throat ○ muscle tension
○ drink alcohol ○ gall-stones ○ ringing in ears ○ sexual disease
○ alternating diarrhea and constipation o indecision

Kidney/Bladder function:

○ sore/weak knees ○ low back pain ○ easily broken bones ○ memory problems
○ excessive hair loss ○ kidney stones ○ lack of bladder control ○ fearful
○ high libido ○ low libido ○ normal libido

Urination:

○ frequent ○ urgent ○ dark yellow color ○ reddish color
○ clear color ○ scanty ○ profuse ○ strong odor
○ burning ○ painful ○ difficult ○ cloudy

Men only:

○ testicular pain ○ swollen testes ○ premature ejaculation ○ impotence
○ coldness or numbness in genitalia o low libido
○ other:____

Women only:

Age of first menses: ______________ Age of menopause: _______

Number of pregnancies: __________ no. of life births ___________ no. of abortion _________

Are you pregnant now? ___________

Vaginal discharge: color: __________ thin/thick: __________ strong odor: ____________

Bleeding: Amount _______________ color: __________ clots: _________cramps: __________

Frequency: ____________________ how long does it last? _____________________________

Do you experience any of the following pre-menstrual syndromes?

○ nausea ○ food cravings ○ depression ○ vomiting

○ headaches ○ irritability ○ water retention ○ migraines

○ anxiety ○ cramps ○ breast tenderness ○ moody

Menstrual Chart

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (bright red, pale, dark)							
Amount of flow(heavy, light)							
Cramps (dull, sharp)							
Clots (large, small, purple, red)							
Nause or vomiting							
Mood							
Breast soreness							

Please, print out this form, fill it in, and bring it with you to your appointment.