Susanti Cai Eastern Healing

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NEW PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: _____ Date: _____
Address: _____
City: _____ State: _____ ZIP: _____
Home or Cell Phone: _____
E-mail: _____
Birthday: _____Age: _____ Time of birth: _____
Gender: ____ Female ____ Male
Height: _____ Weight: _____lbs
Emergency contact: _____ Relationship: _____
Emergency contact number: _____
Who referred you? How did you hear about us? _____

TREATMENT HISTORY

Have you had an acupuncture treatment before? When and for what condition?

_____

Main problem(s) you would like help with:

_____

Have you been given a diagnosis for this problem? If so, please indicate:

_____

Surgeries (list types and dates):

_____

Significant trauma (motor vehicle accidents, falls, etc.):

_____

What kinds of treatments have you tried?

_____

Significant Dental work (types and dates):

_____

FAMILY MEDICAL HISTORY (Please indicate family member):

Allergy: _____ Asthma/Wheezing: _____
Tuberculosis: _____ Heart disease: _____
Digestive tract disorder: _____ Kidney or bladder disorder: _____
Blood disorder/anemia: _____ Diabetes: _____
Tumor or Cancer (type) _____ Seizures: _____
Hypertension: _____ Drug abuse: _____
Stroke: _____ Depression/behavior health illness: _____
Other: _____

YOUR PAST MEDICAL HISTORY (please check):
Cancer (type): _____Diabetes ____ High Blood Pressure ____Heart disease ____
Rheumatic fever ____ Seizures ____ Thyroid disease ____ Venereal disease ____
Other _____
Allergies (drugs, chemicals, foods, reaction): _____

Are you currently taking any steroids? ____ Yes ____ No
Current medications (please circle):

Aspirin Ibuprofen Acetaminophen (Tylenol) Antacids Laxatives
Cold tablets Oral contraceptives Diet pills Tranquilizers Fiber supplements
Sleeping pills Hay fever tablets Blood pressure pills Insulin/diabetic pills

Other _____
Vitamins/supplements _____
Herbs _____

Are you pregnant? ____ Yes ____ No
Do you have regular exercise program? ____ Yes ____ No; Please describe: _____
Are you on restricted food regimen? ____ Yes ____ No; What type: _____
Please describe your average daily food intake:
Breakfast: _____
Lunch: _____
Dinner: _____
Coffee/tea/cola: _____ cups per day/week; started at _____ years old, quit at _____ years old
Tobacco: _____ sticks per day; started at _____ years old, quit at _____ years old
Alcohol: _____ glass per day/week; started at _____ years old; quit at _____ years old
Recreational drugs: _____ use per day/week; started at _____ years old, quit at _____ years old;
Please specify type of recreational drug(s): _____

PLEASE CHECK ANY SYMPTOMS YOU ARE EXPERIENCING:

HEAD, EYES, EARS, NOSE & THROAT

___ Dizziness
___ Migraines
___ Headaches
Time of the day: _____
Location of headache: _____
___ Facial pain
___ Poor vision
___ Blurry vision
___ Night blindness
___ Color blindness
___ Floaters
___ Eye pain
___ Eye strain
___ Cataracts
___ Eye dryness
___ Excessive tearing
___ Eyes discharge
___ Poor hearing
___ Ringing in ears
___ Earaches
___ Discharge from ear
___ Nose bleed
___ Sinus congestion
___ Nasal drainage
___ Teeth grinding
___ Jaw clicking
___ Concussion

___ Recurrent sore throats
___ Hoarseness
___ Sores on lips or tongue
___ Other head or neck problems

CARDIOVASCULAR

___ High blood pressure
___ Low blood pressure
___ Chest discomfort/pain
___ Heart palpitation
___ Cold hands and/or feet
___ Swelling of hands
___ Swelling of feet
___ Blood clots
___ Fainting often
___ Difficulty breathing
___ Other heart or blood vessel problem
_____

RESPIRATORY

___ Asthma/Wheezing
___ Pain with deep breathing
___ Difficulty in breathing when lying down
___ Cough
___ Phlegm production
Color: _____
___ Coughing up blood
___ Pneumonia
___ Bronchitis
___ Other lung problem _____

GASTROINTESTINAL

___ Bad breath
___ Nausea
___ Vomiting
___ Belching
___ Indigestion
___ Diarrhea
___ Constipation
___ Chronic laxative use
___ Blood in use
___ Abdominal pain or cramps
___ Gas
___ Rectal pain
___ Hemorrhoids
___ Other stomach or intestinal problems
_____

GENITO-URINARY

___ Pain on urination
___ Urgency to urinate
___ Frequent urination
___ Blood in urine
___ Decrease in flow
___ Unable to hold urine
___ Dribbling
___ Kidney stones
___ Impotency
___ Change in sexual drive
___ Sores on genitals
___ Other genital or urinary system problem
___ Do you wake to urinate ___ Yes ___ No
How often? _____
___ Any particular color to your urine?
_____

MUSCULOSKELETAL

___ Hip pain
___ Knee pain
___ Foot/ankle pain
___ Muscle pain
___ Muscle weakness
___ Muscle tightness/stiffness
___ Neck pain
___ Shoulder pain
___ Back pain
___ Elbow pain
___ Hand/wrist pain
___ Other: _____

SKIN & HAIR

___ Rashes
___ Itching
___ Eczema
___ Oozing on skin lesion
___ Hives
___ Pimples
___ Loss of hair
___ Other hair or skin problem _____

NEUROPSYCHOLOGICAL

___ Seizures
___ Areas of numbness
___ Weakness
___ Sleep disorders
___ Concussion
___ Bad/quick temper
___ Loss of control/violence
___ Vertigo
___ Lack of coordination
___ Depression
___ Easily susceptible to stress
___ Loss of balance
___ Poor memory
___ Anxiety
___ Substance abuse
___ Other neurological or psychological problem
_____
___ Have you been treated for emotional problem?
____ Yes ____ No
___ Have you considered or attempted suicide?
____ Yes ____ No

PREGNANCY/GYNECOLOGY

___ Number of pregnancies
___ Number of births
___ Premature births
___ Miscarriages
___ Abortions
___ Age at first menses _____
___ Period between menses
___ Duration (days) _____
___ First date of last menses _____
___ Unusual character (heavy/light)
___ Painful periods
___ Changes in body/psyche prior to menses
___ Clots
___ Menopause; age _____
___ Vaginal discharge
___ Post-coital bleeding
___ Vaginal sores
___ Last pap; date _____
___ Breast lumps
___ Nipple discharge
___ Do you use birth control? ___ Yes ___ No
___What type? How long? _____

GENERAL

___ Chills
___ Fever
___ Sweat easily
___ Night sweats
___ Localized weakness
___ Bleed or bruise easily
___ Peculiar taste or smell
___ Strong thirst (hot or cold)
___ Thirst with no desire to drink
___ Fatigue
___ Sudden energy drop
Time of the day _____
___ Edema
Location _____
___ Poor sleeping
___ Tremor
___ Poor balance
___ Unusual cravings
___ Decreased or loss of appetite
___ Weight gain
___ Weight loss