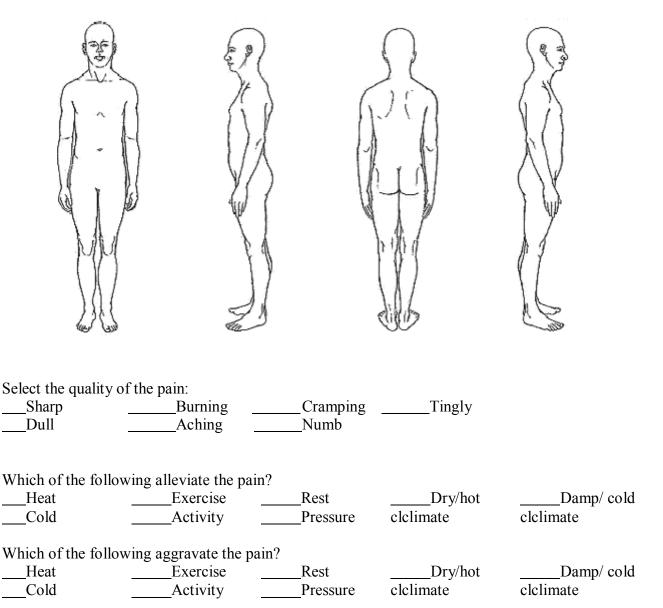


Name:					Date:		
Age: [	Date of Birth:		Sex:	<u>M</u>	F		
Marital Status	Single	Married	<u>Partnered</u>	<u>Separated</u>	Divorced	Widowed	<u>L</u>
Spouse/Partne	er's						Name:
Home Addres	SS:						City:
State:	Z	Zip Code:_				E-mail	Address:
Home Phone:	()_				Ce	ll Phone: (_	)
Employer:						O	ecupation:
Emergency co	ontact:					_ Phone: (	)
Relation:							
Medical Insur	rance Carrier	 					_Policy #
Name	of		your		Medical		Doctor
How	did	you	hear	abo	out	our	clinic?
Who may we	thank for refe	erring vou?					



Patient Name:	Date:		
Please describe your chief cor	mplaint:		
Severity of your complaint:	Mild Moderate 1 2 3 4 5 6 7	Severe 8 9 10	
When did you first experience	e these symptoms?		
Was there any trauma relating	to the onset of your complaint, an	d if so please describe?	
Describe how your complaint a	affects your daily activities:		
What have you done to address	this complaint:		
Describe any lah work or imag	ing you have had done (if any):		
Describe any lab work of illiag	ing you have had done (if any).		

Please mark any areas of pain with an "X", and any major scars with "S"



If no, what time of the day does the pain occur:

\_\_\_Morning \_\_\_\_Afternoon \_\_\_\_Evening \_\_\_\_Night

Does the pain affect your sleep? Y N

Does the pain radiate? <u>Y</u> N\_\_\_\_

Is the pain constant? Y N

Other comments regarding your pain:

Women Only:			
Pregnant? Y N If yes Are you trying to get pregnant? Number of pregnancies:		Number of chil	dren:
Regular Menstrual cycle? Y	N Average 1	number of days o	f bleeding:
Average number of days of entire			5. <u></u>
Vaginal discharge? Y N	· —	een periods?	Y N
If applicable, please check the foDull crampingSharp crampingLow back painBreast tendernessBreast swelling  If applicable, please check the foHot flashesIncreased abdominal fat	BloatingMigrainesHeadachesHunger/cravLow appetit llowing menoparVaginal dry	vings e usal symptoms yo ness	Water retentionIrritabilityDepressionNauseaVomiting
Other			
Men Only:			
Benign prostate hyperplasia (Urinary difficultyUrinary painSpermatorrhea	(ВРН)	Erectile dys Testicular pa Cold sensati	

Beingil prostate hyperplasia (BFH)Urinary difficultyUrinary pain Spermatorrhea	Erectile dystunctionTesticular painCold sensation of external genitalia
Please list any other conditions or concerns re	garding your health:
Current Medications (if any):	
Dietary Supplements (herbs, vitamins, minerals	s, etc):

Pleas	se list your medical histor	y including past conditions, surger	ries, etc:
Plea	ase list your family medic	al history:	
selec			uncture affectively treats. Please e information on how we may be
	IBS Acid reflux Nausea/vomiting Infertility Ovarian cysts Hot flashes Anxiety Depression Insomnia Fatigue Stress Asthma	ArthritisTendonitisSciaticaCarpal tunnelFibromyalgiaCommon coldFluImmune weaknessShinglesBell's PalsyThyroid disordersStroke rehabilitation	Bladder infectionInterstitial cystitisLow libidoVertigoAnemiaGoutMigrainesHeadachesTrigeminal neuralgiaAllergiesSinus infectionsAddiction
	ve Acupuncture's Cance	·	nours of my scheduled appointment
time unde	or if I miss my appointme	ent completely I agree to pay a \$40	
Pleas	se sign and date:		
	Patient Signature:		Date:
	Acupuncturist Signature	2·	Date: