ACUPUNCTURE AND CHINESE MEDICINE CENTER
Eileen Zhuo, L.Ac

New Patient Health History and Office Policy Form

All information is strictly confidential. Please complete as thoroughly as possible.

Date: _____

Name: _____ Age _____ Date of Birth _____/_____/_____

Address _____ City _____ State_____ Zip _____

Telephone (H) _____ (W/C) _____

Guardian (if under 18) _____ Email Address _____

Male ___ Female ___ Height _____'_____ " Weight _____ lb Occupation_____

Married___ Divorced___ Single___ Separated___ Widowed____

Ethnic: Caucasian ____ African American ____ Asian ____ Native American ____ Other _____

How did you hear about us? _____

Emergency Contact _____ Tel: _____ Relation _____

Have you received treatment with acupuncture or Chinese medicine before? Yes ____ No ____

If yes, when _____ where _____ and for what reason _____

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Type of Care Desired

___ Relief Care (symptom relief) ___ Corrective Care (address cause + symptoms)

___ Please choose care type appropriate for my condition

Patient Signature _____ Date _____

YOUR MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE TO YOU:

#1 _____ __Severe __Moderate __Slight

Describe your condition/symptoms:_____

When and how did it start? _____

How does this condition affect daily life? _____

Treatments you've received for this condition? _____

#2 _____ __Severe __Moderate __Slight

Describe your condition/symptoms: _____

When and how did it start? _____

How does this condition affect daily life? _____

Treatments you've received for this condition? _____

#3 _____ __Severe __Moderate __Slight

Describe your condition/symptoms: _____

When and how did it start? _____

How does this condition affect daily life?
_____

Treatments you've received for this condition? _____

YOUR PAST MEDICAL HISTORY (medical conditions, surgeries, or major illnesses with year if you know)

_____

_____

Childhood Health: _____

Allergies (drugs, foods, chemicals) _____

Recent tests: (please indicate test results and date below. Please bring in your lab reports copies)

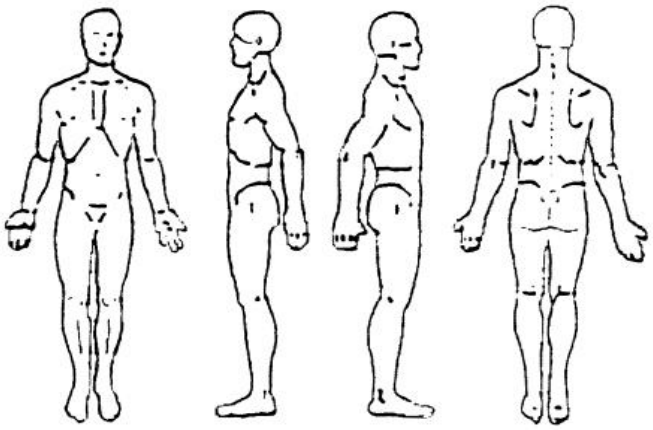
_____

Please list your current medications and Supplements:

_____

DO YOU HAVE PAIN? ___ **YES** ___ **NO** If Yes, please describe pain for each area (please mark on diagram)

1. My worst pain area is my _____



The pain is constant / intermittent / dull aching / sharp / burning
In what degree on a scale of 1-10 (10 = worst):_____
Aggravated By: pressure / cold / heat/exercise
Alleviated By: pressure / cold / heat/exercise
Do you take pain medication? Dose_____,
_____days/wk

2. My next to worst pain area is my _____
The pain is constant / intermittent / dull aching / sharp / burning
In what degree on a scale of 1-10 (10 = worst):_____
Aggravated By: pressure / cold / heat/exercise
Alleviated By: pressure / cold / heat/exercise
Do you take pain medication? Dose_____, _____days/wk

SYSTEMS CHECKLIST (Check all that apply)

General : __ Hot body __ Cold body __ Sweat easily __ Night sweat __ Low energy __ Catch colds easily
__ Strong thirst (cold or hot) __ Thirst, no desire to drink

Liver/Gallbladder: __ Irritability/Anger __ Headaches/Migraines __ Visual Problems __ Dizziness __ Muscle cramps __ Tension
__ Poor Circulation __ Feeling of lump in throat

Heart/Small Intestine : __ Heart palpitations __ Chest pain __ Insomnia __ Anxiety __ Vivid Dreams __ Mouth/tongue sores
___ Lack of joy/humor

Spleen/Stomach: __ Abdominal Pain __ Heaviness anywhere in body __ Fatigue after eating __ Poor appetite __ Crave Sweets
__ Gas/Belching __ Gastritis/Heartburn __ Diarrhea/ Constipation __ Overthinking/worry

Lung/Large Intestine: __ Allergies __Cough /sneeze/phlegm __ Asthma __ Shortness of Breath __ Sinus infection/congestion
__ Skin rashes/Hive __ Grief/Sadness __ Low immunity

Kidney/Urinary Bladder: __ Urinary problems __ Lack of bladder control __ Weakness/Pain in low back _____Low/Excess libido
__ Decreased bone density __ Hot flush/Night sweating __ Tinnitus (low) __ Poor memory

YOUR LIFESTYLE:

Smoke: ___Yes, ___No; How many/day? _____ How many years? ____ Quit ____ When _____

Caffeine/day(coffee, tea, soda) ____ None __; Alcohol/week: _____ None ___ ;

Exercise: ___Yes, ___ No; Type/Frequency:_____

Stress (1-10): work _____ health _____

WOMEN ONLY (Menstruation and Pregnancy History): Age of menopause _____
(If you are looking for Infertility care, please fill out our "Fertility History and Information Form" as well.)

Age of first menstruation _____ Are you pregnant? Yes / No Average days of flow _____
Number of pregnancy _____ Number of birth _____ Bleeding/spotting between Menses___
# of days between menses _____ Practice birth control? Yes / No 1st day of your last period_____

Do you experience any of the following pre-menstrual syndromes (PMS)?
___ Nausea ___ Vomiting ___ Water retention ___ Breast tenderness ___ Food craving ___ Anxiety
___ Irritability ___ Depression ___ Mood swing ___ Poor sleep ___ Headaches ___ Migraines
___ Diarrhea ___ Pain, Where _____(*always /sometimes /recently /in the past*)

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, other)							
Amount of flow (normal, heavy, light, scanty)							
Pain/Cramps (a scale of 1-10)							
Clots (Large, small, dark red)							
Others							

MEN ONLY:
(If you are looking for Infertility care, please fill out our "Fertility History and Information Form" as well.)

___ Swollen testes ___ Testicular pain ___ Impotence ___ Premature ejaculation ___ Infertility (male)
___ Feeling of coldness or numbness in external genitalia Other:_____

ALL PLEASE FILL OUT:

Other Comments:_____

_____

Patient Signature: _____ Date:_____

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Cancellation and Rescheduling Policy

- 3-BUSINESS DAYS notice required for First/New patient appointments to avoid cancellation fee
- A 24-hour notice is required for a return visit to avoid a cancellation fee

Herb and Supplement Return and Exchange Policy

Returns and exchanges must be made within **30** days if it is unopened and not expired.

Payment Policy

- Payment is due at the time of service (check, cash, Zelle, or card-fees apply)
- Monthly statement provided for FSA/HSA reimbursement
- Our office **DOES NOT** bill insurance directly; itemized receipts are available upon request for your insurance for reimbursement.

Acknowledgment

I have read and understood the above policy. I certify that the information provided is accurate to the best of my knowledge.

_____ _____

Signature of Patient Date

Policy Rev. 251121