

CHINESE ACUPUNCTURE HEALTHCARE



11 STATE ROAD, SUITE 300
PRINCETON NJ 08540
609.921.8980 (t)
609.921.8589 (f)

PATIENT INFORMATION					
NAME:					
ADDRESS:	(STREET)			(CITY, STATE, ZIP)	
TELEPHONE:	Check your preferred contact number.				
	<input type="checkbox"/> HOME	<input type="checkbox"/> OFFICE	<input type="checkbox"/> MOBILE		
EMAIL:	<input type="checkbox"/> <i>Subscribe to eNewsletter for health tips and updates</i>				
SSN:		DATE OF BIRTH:	AGE:	HEIGHT:	WEIGHT:
GENDER:	<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE	OCCUPATION/EDUCATION:		
MARITAL STATUS:	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> LIFE PARTNER	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED
DATE OF FIRST VISIT:			REFERRED BY:		
<i>Have tried the following treatments:</i>					
<input type="checkbox"/> ACUPUNCTURE <input type="checkbox"/> HERBAL MEDICINE <input type="checkbox"/> ACUPRESSURE (<i>tui na</i>) <input type="checkbox"/> CRANIOSACRAL					

EMERGENCY CONTACT	PHYSICIAN
CONTACT'S NAME: _____	PHYSICIAN'S NAME: _____
TELEPHONE: (____) _____	TELEPHONE: (____) _____
ADDRESS: (Street, City, _____	ADDRESS: (Street, City, _____
State, ZIP) _____	State, ZIP) _____

MAJOR COMPLAINT

1. _____
2. _____
3. _____

When did you first notice this problem? _____

How long have you experienced this condition? _____

What makes it better? What makes it worse? _____

On a scale of 1 to 10, with 10 being the worst, how would you rate the pain? _____

Have you experienced this condition in the past? _____

YOUR MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Birth Trauma |
| <input type="checkbox"/> Hepatitis A/B/C/D | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Childhood Illnesses | <input type="checkbox"/> Other (<i>please specify</i>): _____ |
| <input type="checkbox"/> Significant Trauma | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | |

FAMILY MEDICAL HISTORY (*Select all that apply and specify which relative*)

- | | |
|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Emotional Disorder _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other conditions: _____ |

LIFESTYLE (*Select all that apply and indicate frequency*)

- | | |
|--|---|
| <input type="checkbox"/> Coffee _____ | <input type="checkbox"/> Tobacco _____ |
| <input type="checkbox"/> Black Tea _____ | <input type="checkbox"/> Recreational Drugs _____ |
| <input type="checkbox"/> Caffeinated Beverages _____ | <input type="checkbox"/> Exercise _____ |
| <input type="checkbox"/> Alcohol _____ | |

MEDICATION, ALLERGIES, AND PAST HOSPITALIZATION

What medications, supplements or herbs are you currently taking? _____

Any allergies? (*food, drugs, etc.*) No Yes (*please specify*):

History of psychiatric treatment? No Yes

Have a cardiac pacemaker? No Yes

Hospitalized in the past year? No Yes (*please specify why*):

Had any major surgeries? No Yes (*list when and why*):

Date of last physical exam:

GENERAL HEALTH

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Large appetite | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Bruise / bleed easily | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Catch colds easily | _____ |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Chills | |

SKIN AND HAIR

- | | | |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Neurodermatitis |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Recent moles | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hives | _____ |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Dry skin | |

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Change in smell |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dry eyes or redness | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Facial pain or numbness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Difficulty in swallowing |
| <input type="checkbox"/> Trigeminal neuralgia | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Change in taste |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Oral ulcers |
| <input type="checkbox"/> TMJ or jaw clicking | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Hay fever / allergies | _____ |

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Coronary heart disease | <input type="checkbox"/> Low blood pressure | _____ |
| <input type="checkbox"/> Chest pain / tightness | <input type="checkbox"/> Swelling of hands / feet | |

RESPIRATORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Frequent / chronic colds |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Coughing phlegm | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Shortness of breath | | _____ |

GASTROINTESTINAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Chronic gastritis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Frequent laxative use |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn / Acid reflux | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Abdominal pain / Cramps | <input type="checkbox"/> Bloody / black stools | _____ |

UROGENITAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Waking at night to urinate | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Genital sores |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Decrease in urine flow | <input type="checkbox"/> Blood in urine | _____ |
| <input type="checkbox"/> Increase in urine flow | <input type="checkbox"/> Impotence | |

MUSCULOSKELETAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Finger pain | <input type="checkbox"/> Chronic lumbar muscle strain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Sprained ankle |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Foot / ankle pain | <input type="checkbox"/> Cervical spondylopathy | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Tennis elbow | <input type="checkbox"/> Other joint/bone problems (<i>please specify</i>): |
| <input type="checkbox"/> Hand / wrist pain | <input type="checkbox"/> Acute lumbar sprain | _____ |

NEUROPSYCHOLOGICAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Concussion | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hemiplegia |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Stress | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Attempted suicide | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> History of psychiatric treatment | _____ |

METABOLISM, ENDOCRINE, AND IMMUNE

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Simple obesity | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic arthritis | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Fibromyalgia | |

MALE REPRODUCTIVE SYSTEM / GENITALIA

- | | | |
|--|---|---|
| <input type="checkbox"/> Pain / itching of genitalia | <input type="checkbox"/> Lumps in testicles | <input type="checkbox"/> Enlarged prostate/prostatitis |
| <input type="checkbox"/> Genital lesions / discharge | <input type="checkbox"/> Impotence | <input type="checkbox"/> Other (<i>please specify</i>): |
| | | _____ |

FEMALE REPRODUCTIVE SYSTEM / GYNECOLOGICAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Painful menses | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> No menses | <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Scanty menstrual flow | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Vulvodynia |
| <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Breast lumps / swelling | <input type="checkbox"/> Vomiting during pregnancy |
| <input type="checkbox"/> Premenstrual syndrome | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Menstrual odor | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> STD | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Urinary tract infection | _____ |

AGE AT:		NO. DAYS:	
	(First Period) (Menopause)		(Period Flow) (Length of Cycle)
COLOR:	<input type="checkbox"/> Brown <input type="checkbox"/> Light red/pink <input type="checkbox"/> Dark red <input type="checkbox"/> Bright red	QUANTITY:	<input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light CLOTS: <input type="checkbox"/> Big <input type="checkbox"/> Small <input type="checkbox"/> None
PMS SYMPTOMS:			
NO. OF PREGNANCIES:	NO. OF LIVE BIRTHS:	NO. OF MISCARRIAGES OR ABORTIONS:	
CURRENT SEXUAL ACTIVITY: <input type="checkbox"/> No <input type="checkbox"/> Yes		CONTRACEPTION (<i>if any</i>):	
PERTINENT PREGNANCY HISTORY:			