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Patient Confidential Information

Name: ……………………………………………………………………………………

Address: …………………………………………………………………………………..…

Phone: ………………………… Email …….…………………………..……………………..……

Date of Birth: ……………………………… Marital Status: ………………………………

Occupation: ………………………………………………………………………………

Emergency Contact: ……………………………………Relationship: ……………………

Phone: ……………………………………………………………………………………

Private Health Provider: ……………………………………………………………………..

Schedule of Fees:

Initial Visit:	$155 (1.5 hour)
Follow-up Visits:	$110 (1 hour)

The Initial Visit: Approximately 1 hour and half and includes:

- A thorough and comprehensive review of your medical history as reported in the Intake Forms you will fill out ahead of time
- A complete diagnostic exam including Pulse and Tongue Diagnosis and channel palpation if indicated
- Nutritional and Lifestyle counseling
- Acupuncture treatment

The Follow-up visits:
Approximately 1 hour and will include a briefer follow-up intake and diagnostic exam followed by a treatment consisting of acupuncture and perhaps one or more of the traditional Chinese modalities depending on your needs that day.

24-HOUR CANCELATION POLICY
Cancellations must be made 24 hours prior to the scheduled appointment. Failure to do so will result in your account being charged for the standard visitation fee. Thank you for your understanding.

Signature: …………………………………

Name: ………………………………………………………………… Date: …..……………

One check (√) for symptoms you SOMETIMES experience.
Two checks (√√) for symptoms that occur OFTEN.
Three checks (√√√) for symptoms of MAJOR CONCERN.

PRESENT HISTORY	WATER ELEMENT	WOOD ELEMENT
chills	hearing loss	headaches
fever	ringing in ears	migraines
sweating	dizziness	ringing in ears
pain	lower back ache	poor eyesight
bedwetting	neck pain	dry/red eyes
Nightly Urination # of times:	sinus congestion	watering eyes
Daily Urination # of times:	edema	eye infections
Bowel Movement # of times daily:	darkness under eyes	blurry vision
long & thin stools	emotional instability	craving for sour taste
dry stools	aversion to cold	eczema
round, small stools, like pebbles	hair thinning or loss	shingles
pale stools	pre-mature aging	herpes
dark stools	frequent urination	warts
exhaustion after bowel movement	kidney stones	nervousness
	perspire very easily	convulsions/spasms
	night sweats	irritability
	afternoon fever	constipation
	weakness of legs/knees sore knees	alternating constipation/ diarrhea
	cold extremities	hepatitis
	asthmatic cough inhalation difficult	ulcer
	rapid weight change	vomiting
	loose teeth	gallstones
	reduced sexual energy	indecisive
	increased sexual energy	fullness below ribs
	thyroid problems	shoulder/neck tension
	diabetes	insomnia 11pm-3 am
	poor memory/concentra-	frustration
	fatigue	depression
	craving for salty taste	anger easily
	thirst for hot drinks	bitter taste in mouth
	dreams of boats/water/ ravines/fear/drowning	hemorrhoids
		wrist & hand pain
		dreams of trees/afraid to get up/fights/cutting your own body

FIRE ELEMENT	EARTH ELEMENT	METAL ELEMENT
dry scalp	indigestion	bronchitis
skin eruptions/rashes	flatulence	asthma exhalation difficult
cysts/tumours	food allergy	shallow breathing
ear infections	stomach ache/ulcer	cough
sore throat/tonsillitis	loose stool	sinus congestion
lymphatic swelling	anemia	nasal infections
craving for bitter taste	bad breath	dry skin
hot hands/feet	sores on mouth	spontaneous sweating
aversion to heat	heart burn	catch colds easily
dry mouth	appetite increased	craving spicy taste
gum problems	appetite decreased	dreams of white/cruel killing/fear/crying/flying/metal/fields/rural landscapes
nose bleed	nausea	
facial redness	abdominal bloating	
itching/burning skin	low body weight	
heart palpitations	bleeding prolonged	
thirst for cold drinks	fatigue	
vivid dreaming	vomiting	
dark urine	bruising easily	
night sweats	organ prolapse	
chest pain	craving for sweet taste	
insomnia: falling asleep	heaviness in legs	
insomnia: waking up	sticky saliva	
sores on tongue	thirst but don't like to drink	
thirst but only like small sips	dreams of food/buildings/walls/singing/music/heavy body/ difficulty getting up/abysses/marshes/	
very thirsty	vaginal infections	
dreams of fire/laughing/fear/hills/mountains/populated cities or streets		
fatigue upon waking		

List your CHIEF COMPLAINTS in order of priority and their date of onset:

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

What types of ACUTE ILLNESSES do you suffer from and approximately how often have you experienced them in the last five years?

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……………………………………………………………………………………………

……………………………………………………………………………………………

List any SERIOUS OR CHILDHOOD ILLNESSES and their approximate dates:

……………. ……………………………………………………………………………

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List all SURGERIES and their approximate dates:

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……………………………………………………………………………………………

……………………………………………………………………………………………

List all prescription DRUGS you are taking and any history of non-prescription & pre-scription drug use (if you need more space, please use back of form):

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……………………………………………………………………………………………

VACCINE History:

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Describe your current program of PHYSICAL FITNESS:

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……………………………………………………………………………………………………

Describe your BIRTH: (Natural?, C-Section?, Mother's situation during pregnancy?)

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……………………………………………………………………………………………………

Number of siblings and ages: …………………………………………………………………..

Number of children and ages: …………………………………………………………………

Describe a typical day's DIET, including beverages:

BREAKFAST	LUNCH	DINNER

Do you drink diet soda? Yes ….. No ….. If yes how many …….
Do you drink coffee? Yes ….. No ….. If yes how many …….
Do you smoke cigarettes? Yes ….. No ….. If yes how many …….
Do you use recreational drugs? Yes ….. No ….. If yes how many …….
Do you consume alcoholic beverages? Yes ….. No ….. If yes how many …….
Do you have any known allergies? Yes ….. No ….. If yes, please describe:

…………………………………………………………………………………………

…………………………………………………………………………………………

MENSTRUATION:
Age of your first menstrual period:

Length of cycle: ……….. days

Length of bleeding: ………days

Amount of blood: Average ….. light ….. heavy …..

Color of blood**:** bright red ….. dark red ….. brown ….. purple …..

Consistency of blood: normal ….. sticky/thick ….. watery ….. clots …..

PMS: breast distention ….. cramps ….. (before ….. during ….. after …..)

headaches ….. location ………………………………………………………………

food cravings ……………………………………………………………………..

bloating ……….. edema ……….. constipation …………

Date of last menstrual period: ……………. Number of pregnancies: ………………….

Is there a possibility you are pregnant now? ………………………………………………

Choose one or two EMOTIONS that are influential in your life which are either frequently experienced or difficult to express:

…………………………………………………………………………………………

…………………………………………………………………………………………

Describe any TRAUMATIC experiences you have had and give their approximate dates (i.e. divorce, change of residence, injury, death in family, bankruptcy, etc.):

DATE:	EVENT:
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Describe briefly your EMPLOYMENT HISTORY:

DATE: EMPLOYMENT:

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Check any FAMILY HISTORY of illness:

asthma	infertility
autoimmune disease	fibroids
heart disease	hepatitis
high blood pressure	stroke
heart attack	miscarriage
migraines	alcoholism/drug addiction
allergies	cancer
arthritis	anemia
epilepsy	mental illness
kidney disease	tuberculosis
diabetes	weight problems
skin disorders	Other: