New Patient Information Form

Date _____

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____State_____ Zip _____ Work Phone _____

Occupation _____ Email _____

DOB _____Age _____ Height _____ Weight _____

Gender: ❑ Man ❑ Woman

Marital Status: ❑ Married ❑ Domestic Partner ❑ Divorced ❑ Widowed ❑ Separated ❑ Single

How did you learn about our clinic?_____

In case of emergency notify: _____

Relationship _____

Their home phone _____Work phone _____ Cell phone _____

Physician _____ Physician's phone _____

Physician Address _____

The reason for your visit?_____

How long have you had this condition?_____ Have you had it in the past? _____

If yes, (in the past) describe when _____

What makes it better?_____

What makes is worse? _____

Is your condition...: ❑ getting worse ❑ getting better ❑ constant ❑ comes and goes

If applicable, circle a number to indicate your level of pain. Minimal = 1 2 3 4 5 6 7 8 9 10 = extreme

If you have been given a diagnosis, what is it?

Diagnosing physician _____ Are any other doctors treating this condition? Y / N

Are you under the care of another physician for any other problems? (list problem and physician):

_____

_____

What kinds of treatments have you tried?_____

List/attach all medications, hormones, laxatives, herbs, homeopathics, and supplements you are taking and for what reason: _____

_____

_____

Medical History

Date of your last physical exam _____ By whom? _____

List surgeries and dates: _____

_____

_____

Significant accidents and traumas with dates: _____

_____

_____

_____

Do you:

❑ Smoke How much and how often: _____

❑ Drink alcohol How much and how often: _____

❑ Take recreational drugs How much and how often: _____

Do you have or have ever had:

❑ AIDS, or HIV	❑ Arthritis	❑ Tuberculosis	❑ Dyslexia
❑ Heart trouble	❑ Cancer	❑ Sexually transmitted disease	❑ Kidney or bladder trouble
❑ Hepatitis	❑ Epilepsy	❑ Thyroid problems	❑ Scarlet fever
❑ Gallstones	❑ Hemophilia	❑ Ulcers	❑ Sudden weight loss
❑ Rheumatic fever			

Have you ever taken adrenal corticosteroids (cortisone, prednisone, etc)? How long? _____

Have you had more than 2 courses of antibiotics in your lifetime? Y / N How many? _____

Do you have silver amalgam fillings? _____

Unusual birth history (prolonged labor, forceps delivery, C-section, etc)? _____

Please list scars from accident/surgery: _____

What inoculations have you had?

❑ Tetanus (lockjaw)	❑ Smallpox	❑ Diphtheria	❑ Poliomyelitis	
❑ Pertussis (whooping cough)	❑ Rubella (German measles)	❑ Measles	❑ Flu	❑ Other _____

What inoculations have you had in the last year? _____

Where have you traveled outside this country? _____

Family Medical History

Has anyone in your family had any of the following disorders?

❑ Alcoholism	❑ Asthma	❑ Diabetes	❑ High blood pressure	❑ Lung disease
❑ Allergies	❑ Cancer	❑ Epilepsy	❑ Kidney disease	❑ Mental disorder
❑ Arthritis	❑ Coronary artery disease	❑ Heart disease	❑ Liver disease	❑ Stroke

Symptoms (Do you suffer from any of the symptoms below)

General

❑ Head or chest cold ❑ Night sweats ❑ Anemia ❑ Recent weight loss ❑ Flu
❑ Perspire easily w/o exertion ❑ Always fatigued ❑ Recent weight gain ❑ Recurrent fever ❑ Rarely perspire
❑ Fatigued easily ❑ Often thirsty ❑ Sudden drop in energy ❑ Chills ❑ Jaundice
❑ Seldom thirsty

Head, Ears, Nose, Mouth and Throat

❑ Frequent colds ❑ Dizziness or loss of balance ❑ Deafness ❑ Sores on tongue
❑ Sinus congestion or pain ❑ Concussion ❑ Nasal congestion ❑ Sores in mouth (canker)
❑ Facial pain ❑ Seizures ❑ Runny nose ❑ Sores on lips (fever blister)
❑ Jaw tension or clicking (TMJ) ❑ Headache ❑ Nose bleeds ❑ Difficulty swallowing
❑ Grinding teeth ❑ Migraine Headache ❑ Sneezing ❑ Lump or pit in throat
❑ Frequent dental cavities ❑ Congestion in ears ❑ Allergies ❑ Sore throat
❑ Gum problems ❑ Earache ❑ Decreased sense of smell ❑ Strep throat
❑ Bleeding gums ❑ Ringing in ears ❑ Dry mouth ❑ Swollen lymph nodes
❑ Dentures ❑ Difficulty hearing ❑ Excessive saliva or drooling ❑ Tonsillitis

Eyes

❑ Nearsighted (myopia) ❑ Night blindness ❑ Eye pain ❑ Conjunctivitis
❑ Farsighted (hyperopia) ❑ Sensitivity to light ❑ Dry eyes ❑ Use eyeglasses or contacts
❑ Astigmatism ❑ Blurred vision ❑ Watery eyes ❑ Blindness
❑ Glaucoma ❑ Floating Spots ❑ Itchy eyes ❑ Cataracts
❑ Pressure behind eyes ❑ Red eyes

Respiratory

❑ Chronic cough ❑ Thin, watery phlegm ❑ Pneumonia ❑ Asthma: more difficult exhale
❑ Dry cough ❑ Clear or white phlegm ❑ Pain with deep breath ❑ Asthma: more difficult inhale
❑ Tight , rattling cough ❑ Yellowish phlegm ❑ Shortness of breath ❑ Asthma: worse on exhale
❑ Loose cough ❑ Blood in phlegm ❑ Emphysema ❑ Thick, sticky phlegm
❑ Bronchitis ❑ Wheezing

Cardiovascular

❑ High blood pressure ❑ Angina or chest pain ❑ Varicose veins ❑ Cold hands
❑ Low blood pressure ❑ Coronary heart disease ❑ Bruise easily ❑ Cold feet
❑ Blackouts or fainting ❑ High cholesterol ❑ Anemia ❑ Hot hands or palms
❑ Irregular heartbeat ❑ Stroke ❑ Edema ❑ Hot feet or soles
❑ Heart valve problem/murmur ❑ Blood clot ❑ Swelling of hands ❑ Generally too hot
❑ Rapid heartbeat/palpitations ❑ Phlebitis ❑ Swelling of feet ❑ Generally too cold

Gastrointestinal

❑ Constipation ❑ Undigested food in stool ❑ Blood in stool ❑ Hiatal hernia
❑ Hard stools ❑ Black stool ❑ Lower abdominal pain/ cramping ❑ Vomiting
❑ Hemorrhoids ❑ Belching ❑ Upper abdominal pain/cramping ❑ Colitis
❑ Frequent laxative use ❑ Stomach acidity ❑ Ulcer ❑ Diarrhea

Gastrointestinal (Continued)

❑ Diverticulitis ❑ Indigestion ❑ Nausea ❑ Loose stools
❑ Parasites ❑ Gurgling noise in stomach ❑ Erratic bowel movements ❑ Mucous in stool
❑ Abdominal bloating ❑ Bad breath ❑ Poor appetite ❑ Gas (flatulence)
❑ Foul smelling stools ❑ Excessive appetite ❑ Bowel movements feel incomplete

How often do you have a bowel movement? _____

Urinary and Genital

❑ Scanty or small amount of urine ❑ Decreased flow of urine ❑ Sores on genitals ❑ Dark urine
❑ Flow does not stop quickly ❑ Pain during intercourse ❑ Strong smelling urine ❑ Dribbling
❑ Excessive sexual energy ❑ Low sexual energy ❑ Cloudy urine ❑ Bed wetting
❑ Profuse or large amount of urine ❑ Inability to achieve orgasm ❑ Low sperm count ❑ Clear urine
❑ Pain or burning when urinating ❑ Pain in bladder area ❑ Prostate problems ❑ Unable to hold urine
❑ Blood in urine ❑ Urgency to urinate ❑ Bladder infection ❑ Premature ejaculation
❑ Ejaculation during sleep ❑ Frequent urination ❑ Kidney infection ❑ Difficulty urinating
❑ Kidney stones ❑ Inability to maintain erection

How often do you urinate in 24 hours? _____ How often do you wake to urinate at night? _____

Pregnancy and Gynecology

❑ Number of pregnancies ❑ Clots ❑ Vaginal discharge:strong odor
❑ Number of births ❑ Dark purple ❑ Vaginal discharge brownish
❑ Premature births ❑ Dark brown ❑ Vaginal discharge:white/curd-like
❑ Miscarriages ❑ Red ❑ Vaginal discharge:frothy &profuse
❑ Abortions ❑ Light colored/pale blood ❑ Vaginal discharge:itchy
❑ Difficult deliveries ❑ Painful periods ❑ Vaginal discharge:burning
❑ Cesarean sections ❑ Endometriosis ❑ Abnormal pap
❑ Age of children ❑ Cramping before period starts ❑ Uterine fibroids
❑ Age at first menses ❑ Cramping after period starts ❑ Ovarian cysts
❑ Date of last menses:__/__/__ ❑ Low backache with period ❑ Breast cysts or lumps
❑ Duration of flow ❑ Spotting between periods ❑ Pelvic inflammatory disease
❑ Length of cycle ❑ Missed periods ❑ Currently have an IUD
❑ Age at start of menopause ❑ Premenstrual irritability ❑ Previously had an IUD
❑ Age menses stopped ❑ Premenstrual emotional sensitivity ❑ Current use of birth control pills
❑ Hysterectomy ❑ Premenstrual breast tenderness ❑ Previous use of birth control pill
Reason for _____ ❑ Premenstrual bloating ❑ Other birth control
❑ Oophorectomy ❑ Premenstrual fluid retention ❑ Cannot maintain pregnancy
Reason for _____ ❑ Premenstrual headache ❑ Trying to become pregnant
❑ Have not yet begun menstruating ❑ Premenstrual constipation ❑ Infertility
❑ Irregular cycle ❑ Premenstrual diarrhea ❑ Pregnant
❑ Heavy flow ❑ Hot flashes ❑ Nursing
❑ Light flow ❑ Vaginal discharge: no odor ❑ Nausea or morning sickness

Any other pregnancy or gynecological problems? _____

Musculoskeletal

❑ Neck pain/stiffness ❑ Mid back pain/stiffness ❑ Leg or calf cramping ❑ Shoulder blade pain

❑ Low back pain/stiffness ❑ Ankle pain/stiffness ❑ Shoulder joint pain/stiffness ❑ Sacroiliac pain/stiffness

❑ Weak ankles ❑ Upper arm pain/stiffness ❑ Hip joint pain/stiffness ❑ Foot or toe pain/stiffness

❑ Elbow pain/stiffness ❑ Pain into thigh or upper leg ❑ Numbness or tingling in feet ❑ Wrist pain/stiffness

❑ Pain into calf or lower leg ❑ Muscle spasms ❑ Hand or finger pain/stiffness ❑ Weak legs

❑ Muscle weakness ❑ Numbness or tingling in hands ❑ Knee pain/stiffness ❑ Paralysis

❑ Upper back pain/stiffness ❑ Weak knees ❑ Stiff all over

Is the problem helped by: pressure_____ heat _____cold _____ other_____

Is the problem aggravated by: pressure_____ heat _____cold _____ other_____

Skin and Hair

❑ Rashes ❑ Herpes Zoster (shingles) ❑ Recent change in mole ❑ Fungus on skin

❑ Hives ❑ Boils ❑ Warts ❑ Fungus under nails

❑ Itching ❑ Pimples or acne ❑ Dry Skin ❑ Weak or brittle nails

❑ Eczema ❑ Ulcerations or sores ❑ Moist feet ❑ Loss of hair

❑ Psoriasis ❑ Recent moles ❑ Moist palms ❑ Dandruff

Any numb areas? ❑ Yes ❑ No Where? _____

Sleep

❑ Difficulty falling asleep, wired ❑ Nightmares ❑ Needs to take naps ❑ Shallow sleep

❑ Snoring ❑ Sleep too much ❑ Dream disturbed sleep ❑ Difficulty waking in a.m.

❑ Sleep too little ❑ Wake at night–thinking ❑ Wake up unrefreshed ❑ Sleep on a waterbed

❑ Sleepy in afternoon ❑ Sleep with an electric blanket ❑ Wake at night-mind empty, eyes open

How many hours do you sleep in a 24 hour period?_____

Emotional

❑ Depression ❑ Mood swings ❑ Frequent crying ❑ Suicidal feelings

❑ Manic episodes ❑ Anxiety or fear ❑ Frequent anger or irritation ❑ Obsessiveness or compulsiveness

❑ Indecisiveness ❑ Sadness or grief ❑ Difficulty handling stress ❑ Tendency to repress emotions

Have you ever been emotionally, physically or sexually abused? _____

Have you ever been treated for emotional problems? _____

Have you had any recent stressful experiences (divorce, death of a loved one, bankruptcy, loss of a job, illness, injury, etc.)? _____

Is there a constant stress in your life, at work, with your family, etc.?_____

Any other emotional problems? _____

_____

The information on these pages is true to the best of my knowledge.

I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept FCH office policy and that I am expected to notify 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

Signed:_____Date: _____

Parent / Guardian (if applicable) _____:

Acupuncture Consent Form

“Acupuncture” means the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body.The potential risks: Slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment. The potential benefits: Acupuncture may allow for the painless relief of one’s symptoms without the need for medications or other invasive therapies, and improve the balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

“With this knowledge, I voluntarily consent to the above procedures.”

_____ Patient Printed Name

_____Patient Signature and Date