DATE _____

PATIENT PROFILE

Last Name: _____ First Name: _____
Nickname: _____ Birthday: _____ Sex: _____
Address:_____
Phone Number: (home) _____ (work) _____
Email: _____

A note to our patients: Please complete this short questionnaire as thoroughly as possible in order to aid in diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance. Include any prior diagnosis of these problems.

1. 4.
2. 5.
3. 6.

What goals do you have for your visit at the clinic today? _____
_____

Have you ever consulted an Acupuncturist or other alternative health care provider before? If so, what kind of practitioner and when? _____
_____

Please list prescription medications that you are currently taking, with dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6._____

List vitamins, minerals, herbs, and homeopathic remedies that you are currently taking, with dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Do you have any severe or life threatening allergies to medications or anything else? □Yes □ No
If YES, please explain: _____

Personal Habits

Please circle any of the following substances that you use regularly:

Tobacco Coffee Black Tea Green Tea Cola Alcohol Recreational Drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____
_____

Do you exercise regularly? □Yes □ No
What type? _____
How long? _____ How often?_____

Past History

Hospitalizations: _____
_____

Serious Illnesses and Injuries:_____
_____

Date of last physical/annual exam _____
Date of last blood tests:_____

Social History:

Please circle those that apply: Single Married Significant Other

Do you have any children? Yes No
Please list their age(s) _____

Personal and Family History

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	Past(P)/Current(C)		YES	RELATION	Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Arthritis				Hepatitis			
Asthma				High Blood Pressure			
Cancer				Kidney Disease			
Depression				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				AIDS or HIV+			

Patient Signature: _____ Date:_____