



New Patient Health History

(920)893-8796

Today's Date: / /

Name: _____ E-Mail: _____ Birthdate: ____/____/____
 SS#: _____-_____-_____
 Address: _____ Marital Status: _____ Age: _____
 M F _____ Ht: _____ Wt: _____
 City, State, Zip _____
 Home Phone _____ Work Phone _____ Occupation _____
 Emergency Contact Name: _____ Emergency Contact Phone: _____

Referred by: _____
 Reason for visit today: _____
 How long have you had this condition? _____
 Is it getting worse? _____
 Does it bother your Sleep Work Other (what?) _____
 What seemed to be the initial cause? _____
 What makes it worse? _____
 What makes it better? _____
 Other concurrent therapies? _____

Have you had acupuncture before? Yes No
 Have you had Chinese herbal medicine? Yes No

Are you under care of a MD/CD/PA? Yes No
 Physician Name: _____

Health Insurance Info.
 Insurance Co. Name: _____ Policy Number: _____
 Address: _____ Group: _____
 Phone: _____

Family Medical History

Allergies: _____	Alcoholism _____	Diabetes _____	Seizures _____
Arteriosclerosis _____	Cancer _____	Heart Disease _____	Stroke _____
Asthma _____	_____	High Blood Pressure _____	

Your Past Medical History (check any you have experienced as a significant part of your medical history)

AIDs/HIV _____	Diabetes _____	Multiple Sclerosis _____	Surgeries (list) _____	Tuberculosis _____
Alcoholism _____	Emphysema _____	Mumps _____	_____	Typhoid Fever _____
Allergies _____	Epilepsy _____	Pacemaker _____	_____	Ulcers _____
Appendicitis _____	Goiter _____	Pleurisy _____	_____	Venereal Disease _____
Arteriosclerosis _____	Gout _____	Pneumonia _____	Thyroid Disorders _____	Whooping Cough _____
Asthma _____	Heart Disease _____	Polio _____	Major Trauma _____	Other (Specify) _____
Birth Trauma _____	Hepatitis _____	Rheumatic Fever _____	(Car, fall, etc – list) _____	
(your own birth) _____	Herpes _____	Scarlet Fever _____	_____	_____
Cancer _____	High Blood Pressure _____	Seizures _____	_____	_____
Chicken Pox _____	Measles _____	Stroke _____	_____	_____

Your Daily Average Diet

Appetite	Low _____	Coffee: Qty _____	Artificial _____	Sugar: Form _____	Water _____
	High _____	Soft Drinks:Qty _____	Sweetener _____	Salty Food _____	cups/day _____

Average Daily Menu: _____

Pharmaceuticals taken in last 2 months: _____

Vitamins/Supplements taken in last 2 months: _____

Your Lifestyle

Alcohol _____	Marijuana _____	Stress _____	Regular Exercise Type: _____	Frequency: _____
Tobacco _____	Drugs _____	Occupational Hazards _____	Type: _____	Frequency: _____

General Symptoms

Poor appetite	Poor Sleep	Bodily heaviness	Chills	Bleed or bruise easily
Heavy appetite	Heavy Sleep	Cold hands or feet	Night sweats	Peculiar taste
Strongly like cold drinks	Dream-disturbed sleep	Poor circulation	Sweat easily	(describe) _____
Strongly like hot drinks	Fatigue	Shortness of breath	Muscle cramps	_____
Recent weight loss/gain	Lack of Strength	Fever	Vertigo or dizziness	_____

Head, Eyes, Ears, Nose, Throat

Glasses	Night blindness	Sores on lips or tongue	Recurrent soar throat	Headaches
Eye strain	Glaucoma	Dry mouth	Swollen glands	Migraines
Eye pain	Cataracts	Excessive Saliva	Lumps in throat	Concussions
Red eyes	Teeth problems	Sinus problems	Enlarged thyroid	Other head or neck problems:
Itchy eyes	Grinding teeth	Excessive phlegm	Nose bleeds	_____
Spots in eyes	TMJ	Color of phlegm: _____	Ringling in ears	_____
Poor vision	Facial pain	Poor hearing	Earaches	_____
Blurred vision	Gum problems			_____

Respiratory

Difficulty breathing when lying down	Tight chest	Cough	Color of phlegm: _____	Coughing blood
Shortness of breath	Asthma/wheezing	Wet or dry? _____	Thick or thin? _____	Pneumonia

Cardiovascular

High blood pressure	Low blood pressure	Chest pain	Tachycardia	Phlebitis
Blood clots	Fainting	Difficulty breathing	Heart palpitations	Irregular heartbeat

Gastrointestinal

Nausea	Bad breath	Mucous in stools	Hemorrhoid	
Vomiting	Diarrhea	Intestinal pain or cramping	Anal fissures	
Acid regurgitation	Constipation	Itchy anus	Bowel Movements:	
Gas	Laxative use	Burning anus	Frequency: _____	Texture/form: _____
Hiccup	Black stools	Rectal Pain	Color: _____	Odor: _____
Bloating	Bloody stools			

Musculoskeletal

Neck/shoulder pain	Upper back pain	Joint pain	Limited range of motion	Other (describe):
Muscle pain	Low back pain	Rib pain	Limited use	_____

Skin & Hair

Rashes	Eczema	Dandruff	Change in hair/skin texture	Other hair/skin problems:
Hives	Psoriasis	Itching	Fungal infections	_____
Ulcerations	Acne	Hair loss		_____

Neuropsychological

Seizures	Poor memory	Irritability	Considered/attempted	Other (specify)
Numbness	Depression	Easily Stressed	suicide	_____
Tics	Anxiety	Abuse Survivor	Seeing a therapist	_____

Genito-urinary

Pain on urination	Blood in urine	Venereal disease	Increased libido	Impotence
Frequent urination	Unable to hold urine	Bedwetting	Decreased libido	Premature ejaculation
Urgent urination	Incomplete urination	Wake to urinate	Kidney Stone	Nocturnal emission

Gynecology

Age menses began: _____	Irregular periods	Breast lumps	Date of last PAP
Length of cycle (day 1 to day 1)	Painful periods	# Pregnancies: _____	_____
	PMS	#Live births: _____	
Duration of flow	Vaginal discharge color: _____	Premature births: _____	Date of last period
		Age at menopause: _____	_____

Other: _____
