



**Confidential New Patient Information**

First Name _____	Last Name _____
Address _____	City & Zip Code _____
Home Phone _____	Work Phone _____ Cell Phone _____
SSN # _____	Date of Birth _____
Emergency Contact Name _____	Emergency Contact Phone _____
Marital Status _____	Occupation _____
Referred by _____	Primary Care Dr. _____

**Insurance Information**

Health Insurance Co. _____	Policy/ID # _____
Name on Card _____	Relationship to Patient _____ DOB _____

**Seeking Treatment for**

Please list ALL conditions for which you are seeking treatment, in order of significance to you.

1.	_____	How long	Yrs/mo.
Therapies Tried	_____	Did/Does it help?	Yes/No
Who is currently treating you for this?	_____		
2.	_____	How long	Yrs/mo.
Therapies Tried	_____	Did/Does it help?	Yes/No
Who is currently treating you for this?	_____		
3.	_____	How long	Yrs/mo.
Therapies Tried	_____	Did/Does it help?	Yes/No
Who is currently treating you for this?	_____		

**Additional Information** – Please attach further pages if necessary

<b>MEDICATIONS/SUPPLEMENTS/VITAMINS</b> Please list ALL medications, supplements and vitamins you are taking – please include the dosage
Medications
Supplements
Vitamins
<b>ALLERGIES</b> - Please list ALL known allergies
<b>SURGERIES/HOSPITALIZATIONS</b> - Please list ALL surgeries/hospitalizations, the year they occurred and for what reason
<b>EMOTIONAL/PHYSICAL TRAUMA</b> - Please list ALL emotional and physical traumas (death, divorce, births, car accidents etc)

**PAIN-** indicate on the diagram where you experience

pain

Is the pain:

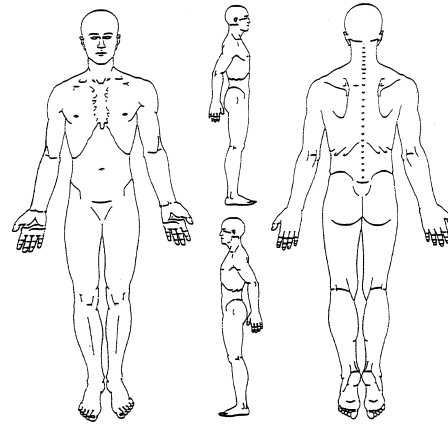
- Sharp
- Cramping
- Fixed
- Burning
- Dull
- Other: \_\_\_\_\_
- Aching
- Moving

Do the following improve the pain?

- Pressure
- Exercise
- Cold
- Rest
- Heat

Do the following worsen the pain?

- Pressure
- Other: \_\_\_\_\_
- Cold
- Heat



**MEDICAL HISTORY** – please check any tests taken in the last 12 months

- Physical
- MRI
- HIV/AIDS
- Cholesterol
- X-rays
- Hepatitis A/B/C
- Blood workup
- CAT scan
- Thyroid
- Mammogram
- Colonoscopy
- Pap smear
- Stress Test
- Prostate
- Other: \_\_\_\_\_

Significant Results

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**Please check any of the following that currently pertain to you:**

**Overall Temperature (Yin & Yang)**

The following symptoms indicate an imbalance of Yin and Yang in your body. In Oriental Medicine, Yin is the cool, moist, nourishing aspect of the body. Yang is the hot, dry, invigorating aspect of the body.

- Cold hands
- Cold feet
- Sweaty hands
- Hot body temperature (sensation)
- Afternoon flushes
- Heat in the hands, feet & chest
- Thirsty
- Lack of perspiration
- Cold fingers
- Cold toes
- Sweaty feet
- Cold body temperature (sensation)
- Night sweats
- Hot flashes any time of the day
- Perspire easily
- Take water to bed

**Overall Energy (Lung, Kidney function)**

- Shortness of breath
- General weakness
- Low energy
- Difficulty keeping eyes open in the daytime
- Easily catch colds
- Feel worse after exercise

**Overall Blood (Liver, Spleen, Heart function)**

- Dizziness
- See floating black spots

**Heart Function**

The following symptoms are indicators of heart malfunction. The heart governs the blood and blood vessels, manifests on the complexion, governs the emotions, and affects speech and taste controls and perspiration.

- Palpitations
- Sores on the tip of the tongue
- Mental confusion
- Frequent dreams
- Drink coffee (# cups per day : \_\_\_\_\_)
- Anxiety
- Restlessness
- Chest pain traveling to the shoulder
- Wake unrefreshed

## Lung Function

The following symptoms are indicators of lung malfunction. The lungs govern breathing, control the movement of energy, control the immune system, regulate water passages, control the skin and open the nose, throat and sinuses.

– Nasal Discharge (Color: _____)	– Cough
– Nose Bleeds	– Sinus Congestion
– Dry mouth	– Dry throat
– Dry nose	– Dry skin
– Allergies (To what: _____)	
– Alternating fever and chills	– Sneezing
– Headache (Location: _____)	– Overall achy feeling in the body
– Stiff neck	– Stiff shoulders
– Sore throat	– Difficulty breathing
– Smoke cigarettes (# per day: _____)	– Sadness
– Melancholy	

## Spleen Function

The following symptoms are indicators of spleen malfunction. The spleen assists in breaking food down into usable nutrients and then transports those nutrients throughout the body, keeps the blood in the blood vessels, governs the muscles, manifests in the lips and holds the organs up in the body.

– Low appetite	– Abrupt weight gain
– Abrupt weight loss	– Abdominal bloating
– Abdominal gas	– Gurgling noise in the stomach
– Fatigue after eating	– Prolapsed organs (prev. diagnosed, where : _____)
– Easily bruised	– Hemorrhoids
– Pensive	– Over-thinking
– Worry	

## Spleen, Stomach, Large Intestines, Small Intestine Function

– Loose	– Constipated
– Incomplete stools	– Diarrhea
– Blood in stools	– Mucous in stools
– Undigested food in stools	

## Dampness Trapped in the Body

The following symptoms are indicators of “dampness” which simply refers to fluids that are not metabolized effectively and cause health problems in the body.

– Mental heaviness	– Mental sluggishness
– Mental foginess	– Swollen hands
– Swollen feet	– Swollen joints
– Chest congestion	– Nausea
– Snoring	– General sensation of heaviness in the body

## Stomach Function

The following symptoms are indicators of stomach malfunction. The stomach controls the breakdown of food and nutrients, descends the energy and is the origin of the body's fluids.

– Burning sensation after eating	– Large appetite
– Bad breath	– Mouth (canker) sores
– Bleeding, swollen or painful gums	– Heartburn
– Acid regurgitation	– Ulcer (diagnosed)
– Belching	– Hiccoughs
– Stomach pain	– Vomiting

## Liver, Gall Bladder Function

The following symptoms are indicators of liver malfunction. The liver stores the blood, ensures the smooth flow of energy throughout the body, nourishes the tendons and ligaments, manifests in the nails and opens in the eyes. The gall bladder stores bile, which breaks down fats.

- |                          |  |                          |   |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | Chest pain   | <input type="checkbox"/> | Alternating diarrhea & constipation                 |
| <input type="checkbox"/> | Tight sensation in chest   | <input type="checkbox"/> | Bitter taste in mouth                               |
| <input type="checkbox"/> | Anger easily   | <input type="checkbox"/> | Frustration   |
| <input type="checkbox"/> | Depression   | <input type="checkbox"/> | Irritability  |
| <input type="checkbox"/> | Frequently unable to adapt to stress (What causes the stress? _____) | <input type="checkbox"/> |   |
| <input type="checkbox"/> | Skin rashes  | <input type="checkbox"/> | Headache at the top of the head                     |
| <input type="checkbox"/> | Tingling sensation   | <input type="checkbox"/> | Numbness  |
| <input type="checkbox"/> | Muscle spasms  | <input type="checkbox"/> | Muscle twitching                                    |
| <input type="checkbox"/> | Muscle cramps  | <input type="checkbox"/> | Seizures  |
| <input type="checkbox"/> | Convulsions  | <input type="checkbox"/> | Lump in the throat                                  |
| <input type="checkbox"/> | Neck tension   | <input type="checkbox"/> | Limited range of motion – neck                      |
| <input type="checkbox"/> | Shoulder tension   | <input type="checkbox"/> | – Limited range of motion - shoulder                |
| <input type="checkbox"/> | Hip pain   | <input type="checkbox"/> | – Drink Alcohol (Type? _____, How much/week? _____) |
| <input type="checkbox"/> | High-pitched ringing in ears   | <input type="checkbox"/> | Recreational Drugs (Which? _____ How often? _____)  |
| <input type="checkbox"/> | Gall stones (history or current)                                     | <input type="checkbox"/> | Sexually transmitted diseases (Which? _____)        |

### Eyes (Liver function)

- |                          |               |                          |                        |
|--------------------------|---------------|--------------------------|------------------------|
| <input type="checkbox"/> | Itchy         | <input type="checkbox"/> | Bloodshot              |
| <input type="checkbox"/> | Hot           | <input type="checkbox"/> | Dry                    |
| <input type="checkbox"/> | Watery        | <input type="checkbox"/> | Gritty                 |
| <input type="checkbox"/> | Blurry vision | <input type="checkbox"/> | Decreased night vision |
| <input type="checkbox"/> | Near-sighted  | <input type="checkbox"/> | Far-sighted            |

### Kidney, Urinary Bladder Function

The following symptoms are indicators of kidney or urinary bladder malfunction. The kidney and adrenal system govern birth/growth/reproduction/development, produce the bone marrow, nourish the brain, control the bones, govern water, open to the ears, manifest the hair, and control the ureter/spermatic duct and lower section of the large intestine. The urinary bladder stores and eliminates impure fluids from the body.

- |                          |                             |                          |  |
|--------------------------|-----------------------------|--------------------------|--|
| <input type="checkbox"/> | Frequent cavities           | <input type="checkbox"/> | Easily broken bones                        |
| <input type="checkbox"/> | Sore knees                  | <input type="checkbox"/> | Weak knees                                 |
| <input type="checkbox"/> | Cold sensation in the knees | <input type="checkbox"/> | Low back pain                              |
| <input type="checkbox"/> | Memory problems             | <input type="checkbox"/> | Excessive hair loss                        |
| <input type="checkbox"/> | Low-pitched ringing in ears | <input type="checkbox"/> | Kidney stones                              |
| <input type="checkbox"/> | Bladder infections          | <input type="checkbox"/> | Wake during night to urinate twice or more |
| <input type="checkbox"/> | Lack of bladder control     | <input type="checkbox"/> | Fear                                       |
| <input type="checkbox"/> | Easily startled             | <input type="checkbox"/> |  |

### Urination

- |                          |              |                          |             |                          |           |
|--------------------------|--------------|--------------------------|-------------|--------------------------|-----------|
| <input type="checkbox"/> | Normal color | <input type="checkbox"/> | Dark yellow | <input type="checkbox"/> | Clear     |
| <input type="checkbox"/> | Reddish      | <input type="checkbox"/> | Cloudy      | <input type="checkbox"/> | Scanty    |
| <input type="checkbox"/> | Profuse      | <input type="checkbox"/> | Strong odor | <input type="checkbox"/> | Burning   |
| <input type="checkbox"/> | Painful      | <input type="checkbox"/> | Discharge   | <input type="checkbox"/> | Difficult |
| <input type="checkbox"/> | Urgent       | <input type="checkbox"/> | Frequent    | <input type="checkbox"/> |           |

### Libido

- |                          |        |                          |      |                          |     |
|--------------------------|--------|--------------------------|------|--------------------------|-----|
| <input type="checkbox"/> | Normal | <input type="checkbox"/> | High | <input type="checkbox"/> | Low |
|--------------------------|--------|--------------------------|------|--------------------------|-----|

### Women Only Menstrual Cycle

Regular Menstrual Cycle \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Pregnant \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Number of Pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_  
 Age of First Menstruation: \_\_\_\_\_ Age of Menopause (if applicable): \_\_\_\_\_  
 Average number of days of flow: \_\_\_\_\_ Average number of days of entire cycle: \_\_\_\_\_

Do you experience:  
 \_\_\_\_\_ vaginal discharge \_\_\_\_\_ Bleeding between periods

Do you experience any of the following pre-menstrual symptoms?  
 \_\_\_\_\_ nausea \_\_\_\_\_ vomiting \_\_\_\_\_ food cravings  
 \_\_\_\_\_ water retention \_\_\_\_\_ breast swelling \_\_\_\_\_ headaches  
 \_\_\_\_\_ migraines \_\_\_\_\_ breast tenderness \_\_\_\_\_ depression  
 \_\_\_\_\_ irritability \_\_\_\_\_ anxiety  
 \_\_\_\_\_ other emotions: \_\_\_\_\_  
 \_\_\_\_\_ dull pain (Where? \_\_\_\_\_)  
 \_\_\_\_\_ sharp pain (Where? \_\_\_\_\_)

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color – normal, bright red, pale, brown, rust, dark, purple, other							
Amount of Flow – normal, heavy, light							
Pain/cramps – location, dull, sharp, other							
Clots – large, small, black, purple, red, other							
Vomiting – yes, no							
Nausea – yes, no							
Other							

**Men Only**

\_\_\_\_\_ Swollen testes \_\_\_\_\_ Testicular Pain \_\_\_\_\_ Impotence  
 \_\_\_\_\_ Premature ejaculation \_\_\_\_\_ Feeling of coldness/numbness in external genitalia  
 \_\_\_\_\_ Other: \_\_\_\_\_

Practitioner Notes:

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All please fill out:

Other Comments:

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Patient Signature: