CENTER FOR ACUPUNCTURE AND HERBAL MEDICINE, PA
166 Mountain Avenue ☯ Westfield, NJ 07090
(908) 654-4333 ☯ www.acupunctureandherbalmedicine.com

PATIENT INFORMATION

Name Date

Home Address

City State Zip Phone

E-mail Address Cell Phone:

Business Address

City State Zip Phone

Occupation

Place of Birth

Date of Birth Age Height Weight Soc. Sec. #

Sex Marital Status (Single, Married, Life Partner, Divorced, Widowed)

In Case of Emergency Notify

How did you hear of this office?

Have you ever before tried acupuncture or Chinese herbal medicine?

CHIEF COMPLAINT

What are the main health problems for which you are seeking treatment?

Please rate the extent to which your current complaint affects your daily life (1 = minor; 10 = major)

Please rate your commitment to resolving this problem (1 = minor; 10 = major)

What other forms of treatment have you sought?

PAST MEDICAL HISTORY (check all which apply)

☐ Allergies	☐ Cancer	☐ Diabetes
☐ Hepatitis	☐ High Blood Pressure	☐ Heart Disease
☐ Seizures	☐ Rheumatic Fever	☐ Surgeries
☐ Venereal Disease	☐ Thyroid Disease	☐ Birth Trauma (see pp. 4-6)
☐ Vaccinations	☐ Childhood Illnesses	☐ Accidents
☐ Significant Trauma (see p. 7)	☐ Medications	☐ Other (please specify)

FAMILY MEDICAL HISTORY (check all which apply and specify which blood relative)

☐ Cancer	☐ High Blood Pressure	☐ Hepatitis
☐ Rheumatic Fever	☐ Infectious Disease	☐ Diabetes
☐ Heart Disease	☐ Seizures	☐ Emotional Disorder
☐ Tuberculosis	☐ Other (please specify)	

LIFESTYLE (please indicate the use and frequency of the following)

☐ Coffee	☐ Black Tea	☐ Tobacco
☐ Alcohol	☐ Caffeinated Beverages	☐ Recreational Drug
☐ Exercise (please specify type)		

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MEDICATIONS

Please list any medications and/or supplements you are currently taking

GENERAL HEALTH (please check all that apply)

- ☐ Poor Appetite
- ☐ Fatigue
- ☐ Cold Hands and Feet
- ☐ Tremors
- ☐ Strong Thirst
- ☐ Poor Balance
- ☐ Cravings
- ☐ Soft/Brittle Nails
- ☐ Disturbed Sleep
- ☐ Poor Coordination
- ☐ Night Sweats
- ☐ Large Appetite
- ☐ Weight Loss
- ☐ Bruise/Bleed Easily
- ☐ Chills
- ☐ Catch Colds Easily
- ☐ Insomnia
- ☐ Weight Gain
- ☐ Cold Abdomen
- ☐ Localized Weakness
- ☐ Fevers
- ☐ Sweat Easily
- ☐ Sudden Energy Drop
- ☐ Other (please specify)

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Psoriasis
- ☐ Pimples
- ☐ Itching
- ☐ Redness
- ☐ Hair Loss
- ☐ Recent Moles
- ☐ Dandruff
- ☐ Eczema
- ☐ Hives
- ☐ Other (please specify)

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Floaters
- ☐ Ringing in Ears
- ☐ Headaches
- ☐ Sores on Lips/Tongue
- ☐ Nosebleeds
- ☐ Toothaches
- ☐ Eye Pain
- ☐ Spots in Eyes
- ☐ Poor Hearing
- ☐ Migraines
- ☐ Dry Mouth/Throat
- ☐ Facial Pain
- ☐ Other (please specify)
- ☐ Blurred Vision
- ☐ Night Blindness
- ☐ Earaches
- ☐ Recurrent Sore Throats
- ☐ Bleeding Gums
- ☐ Jaw Clicking

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Irregular Heart Beat
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Low Blood Pressure
- ☐ Fainting
- ☐ Swelling of Hands/Feet
- ☐ Palpitations
- ☐ High Blood Pressure
- ☐ Cold Hands/Feet
- ☐ Blood Clots
- ☐ Other (please specify)

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Pain with deep breath
- ☐ Difficulty breathing when lying down
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Coughing Phlegm
- ☐ Nasal Congestion
- ☐ Other (please specify)

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GASTROINTESTINAL

☐Nausea	☐Vomiting	☐Diarrhea
☐Constipation	☐Gas	☐Bloating
☐Belching	☐Abdominal Pain/Cramps	☐Indigestion
☐Heartburn/Reflux	☐Retention of Food in Stomach	☐Lack of Appetite
☐Excessive Appetite	☐Rectal Pain	☐Black Stools
☐Blood in Stool	☐Hemorrhoids	☐Bad Breath
☐Sensitive Abdomen	☐Chronic Laxative Use	☐Other (please specify)

GENITO-URINARY

☐Pain on Urination	☐Frequent Urination	☐Blood in Urine
☐Urgency to Urinate	☐Unable to Hold Urine	☐Kidney Stones
☐Decrease in Urine Flow	☐Impotence	☐Sores on Genitals
☐Waking at Night to Urinate	☐Other (please specify)	

REPRODUCTIVE/GYNECOLOGICAL

Age of 1st Period _____	Age at menopause _____	# Pregnancies _____
# Live Births_____	# Premature Births _____	# Miscarriages/Abortions ___
# days between periods _____	# days of flow _____	Color of blood _____
☐Clots (Color _____)	☐Painful Menses	☐Irregular Menses
☐Premenstrual Symptoms	☐Strong Menstrual Odor	☐Vaginal Discharge
☐Vaginal Odor	☐Vaginal Dryness	☐Fibroids
☐Breast Lumps/Swellings	☐Endometriosis	☐Ovarian Cysts
☐Sexually Transmitted Disease	☐Urinary Tract Infection	☐Hot Flashes
☐Decreased Sex Drive	☐Positive Mammogram/Pap Smear	☐Other (please specify)

MUSCULO-SKELETAL

☐Neck Pain	☐Back Pain	☐Knee Pain
☐Muscle Pain	☐Foot/Ankle Pain	☐Shoulder Pain
☐Hip Pain	☐Hand/Wrist Pain	☐Sciatica
☐Muscle Weakness	☐Other Joint/Bone Problems (please specify)	

NEURO-PSYCHOLOGICAL

☐Seizures	☐Dizziness	☐Loss of Balance
☐Areas of Numbness	☐Poor Memory	☐Lack of Coordination
☐Concussion	☐Depression	☐Anxiety
☐Bad Temper	☐Easily Stressed	☐Attempted Suicide
☐Treated for Emotional Problems		☐Other (please specify)

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Please provide as much information as you have available. Talk to family members to fill in the gaps. Much of this information is usually available as family anecdotes. For each question, check "Yes, " "No," or "Unsure," and in addition report as much detail as you can.

BIRTH, INFANCY, CHILDHOOD HISTORY and TRAUMA HISTORY

A. **Prior to Pregnancy**

1. Did your father drink excessive amounts of alcohol during the three month period prior to your conception? ❒ Yes ❒ No ❒ Unsure
If yes, please describe

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2. Did your mother drink excessive amounts of alcohol during the three month period prior to your conception? ❒ Yes ❒ No ❒ Unsure
If yes, please describe.

---

3. Age of father at conception: _____

4. Age of mother at conception: _____

5. If siblings, what number child are you. _____. List number of years between siblings.

---

6. Did either of your parents have a venereal disease prior to or during pregnancy?
❒ Yes ❒ No ❒ Unsure
If yes, please describe

---

7. Did your mother have a prior history of miscarriages?
❒ Yes ❒ No ❒ Unsure
If yes, please describe

---

8. Was your mother exposed to toxins or chemicals around the time of conception?
❒ Yes ❒ No ❒ Unsure
If yes, please describe

B. **During Pregnancy**

1. Did your mother have any illnesses during pregnancy?

❒ nausea/vomiting	❒ cancer	❒ eclampsia/hypertension
❒ AIDS	❒ placenta previa	❒ heart defect
❒ rubella in 1st trimester	❒ edema	❒ other (please describe)

If yes, please describe

---

2. Did she experience any emotional shock or stresses?
❒ death of someone close ❒ loss of job ❒ divorce
❒ trauma or abuse ❒ other (please describe)
If yes, please explain

_____

3. Did she have adequate nutrition? ❒ Yes ❒ No ❒ Unsure

4. Was she on any medications? Please list. -

_____

_____

5. During pregnancy, did she use ❒ alcohol ❒ cigarettes ❒ other drugs or chemicals
Please
list_____

6. Did she spend significant time in the presence of a smoker? ❒ Yes ❒ No ❒Unsure

7. Describe any other conditions, habits, traumas (emotional or physical, i.e., falls, accidents) that might have affected the pregnancy.

_____

_____

C. During Delivery

1. Was birth: ❒ early ❒ late ❒ on time ❒Unsure
If early/late, by how many days/weeks? _____

2. Nature of birth: ❒ Vaginal ❒ C-section

3. Was labor of ❒ natural onset ❒ induced ❒Unsure
If induced, by what method? _____

4. How long of a time elapsed between first contraction and delivery? If actual time is not known, descriptive words such as very fast or very long will do.

_____

5. Was the birth traumatic to you or to your mother? ❒ Yes ❒ No ❒ Unsure
❒ forceps ❒ cold or shivering ❒ extreme pain
❒ excessive bleeding ❒ epidural ❒ other (please explain)

If yes, please explain

_____

6. Describe any unusual circumstances surrounding your birth
   ❒ breech ❒ cord wrapped around neck ❒ forceps
   ❒ born blue ❒ stuck in birth canal ❒ jaundiced
   ❒ umbilical or other hernia ❒ other (please explain)

   Please explain

   _____

7. Was your mother kept in the hospital beyond the usual post-delivery period?
   ❒ Yes ❒ No ❒ Unsure
   If yes, why?

   _____

8. Were you kept in the hospital beyond the usual post-delivery period?
   ❒ Yes ❒ No ❒ Unsure
   If yes, why?

   _____

9. Were you placed in an incubator after birth? ❒ Yes ❒ No ❒ Unsure
   If yes, how long? _____

D. Your Infancy

1. Was your general state of health at birth and during the first few months of your life
   ❒ Good ❒ Fair ❒ Poor
   Describe any problems.

   _____

2. Nutrition: Were you: ❒ breastfed ❒ bottlefed ❒ combination
   If breastfed, for how long? _____.
   Describe any special information about your nutrition as an infant (i.e., allergies, special formula, etc.) _____

3. Were there any emotional traumas in your infancy, either to you or to other members of your close family? ❒ Yes ❒ No ❒Unsure
   If yes, please describe.

   _____

4. Were there any physical traumas to you in your infancy? ❒ Yes ❒ No ❒ Unsure
   If yes, please describe.

   _____

5. Sleep patterns: Please describe any unusual sleep patterns.

   _____

6. Colic? _____

7. Other illnesses or hospitalizations. _____

E. Childhood

1. Did you have any recurring health problems in childhood? ❒ Yes ❒ No ❒ Unsure
   - ❒ Earaches ❒ Colds and sore throats ❒ Digestive problems
   - ❒ Tonsils removed ❒ Musculo-skeletal problems ❒ Developmental problems
   - ❒ Other _____ (please describe)

   If yes, please describe _____

2. Did you have any major illnesses other than the usual childhood illnesses?
   - ❒ Yes ❒ No ❒ Unsure

   If yes, please describe _____

3. Did you experience any physical trauma or physical, emotional or sexual abuse in childhood?
   - ❒Physical ❒ Emotional ❒ Sexual

   If so, describe: Age _____ Nature _____

4. Were you able to engage in normal physical activities commensurate with your age?

_____

5. Did you have any learning disabilities during childhood? _____

F. Traumas

1. In infancy or childhood have you ever been:
   - ❒ neglected ❒ abandoned ❒ physically abused
   - ❒ emotionally abused ❒ sexually abused ❒ separated from your family
   - ❒ other abuse or trauma (please describe) _____

2. In infancy or childhood did you:
   - ❒ experience the death of a parent or loved one ❒ have parents who divorced
   - ❒ other stress in the household (please describe) _____

3. In infancy or childhood have you ever:
   - ❒ broken any bones ❒ been injured in an accident ❒ suffered a concussion
   - ❒ other injuries (please describe) _____

4. During adolescence have you ever been:
   - ❒ physically assaulted ❒ victim of a violent crime ❒ sexually abused
   - ❒ other abuse or trauma (please describe) _____

5. During adolescence have you ever:
   - ❒ broken any bones ❒ been injured in an accident ❒ suffered a concussion
   - ❒ other injuries (please describe) _____

6. At any other point in your life have you ever been:
   - ❒ emotionally abused ❒ physically abused ❒ sexually abused
   - ❒ victim of a crime ❒ divorced/widowed ❒ other trauma (please describe)

_____