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31348 Via Colinas Suite 105 Westlake Village, CA 91362 Phone: (818) 825-8267 Fax: (818) 575-9098

Patient Personal Information

These forms are **CONFIDENTIAL** and are vital to help us determine the best possible treatment for you.
Please fill out **all** the forms to the best of your knowledge.

Today's Date: _____ / _____ / _____ Month Day Year
Name: _____ (Last) (First) (M.I.)
Home Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone #'s: Home _____ - _____ - _____ Cell: _____ - _____ - _____
E Mail Address: _____
Date of Birth: ____/____/____ Age: ____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
S.S.N: _____ Driver's License # _____
Emergency Contact # ____/____/____ Relationship: _____
Employed: Yes: ____ No: ____ Retired: Yes: ____ Employer's Name: _____ Occupation: _____ Employer's Address: _____ City: _____ State: _____ Zip: _____ Employer's Phone #: _____ - _____ - _____
Health Insurance: Yes: ____ No: ____ Insurance Company's Name: _____ Insured Name: _____ ID# _____ Insured Date of Birth: ____/____/____ Month Day Year Relationship to Insured: Self: ____ Spouse: ____ Child: ____ Other: ____ 18 years and under, person's name responsible for your treatment: _____
Have you had acupuncture treatment before? Yes: ____ No: ____
Whom may we thank for the referral? _____ Or How were you referred to us? _____

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Name: _____ Date: _____ / _____ / _____

Height: _____ Weight: _____ Blood pressure: _____ / _____

Chief Complaints (What are the chief complaints you would like us to help you with?)	
	<p>Mark Pain Areas</p>
How long have you had this particular problem? (Be specific)?	
What other forms of treatment have you sought?	
Are you taking any medications? If yes, Please list all:	

- Pain began: Gradually Suddenly Don't know
- Is your pain worse when you: Sit Bend Walk Run Exercise Lift Push Pull Rest
 Other: _____
- Is the pain: Burning Stabbing Sharp Dull/Achy Numb Constant
- Which of the following areas do you have pain, discomfort, or restriction of motion:
 Neck Shoulder Arm Hands Wrist Upper Back Mid Back Low Back Pelvis Hip
 Legs Knees Feet Ankles Other: _____
- Does your Pain travel: Yes No If yes, describe: _____
- When is the pain worst: Morning Afternoon Evening Night
- Does your pain interfere with your: Work Sleep Daily routine
- How would you rate your pain on a scale 1 to 10, with 10 being the most extreme: 1 2 3 4 5 6 7 8 9 10

HEALTH CONDITIONS

- Surgeries: _____
- Traumas: (Auto accident / fall / other:) _____
- Allergies: (Drugs / Chemicals / Food/ Other:) _____

Please check all that apply to you.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Anxiety	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back pain	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Breathing difficulties
<input type="checkbox"/> Cancer	<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Chronic fatigue
<input type="checkbox"/> Constipation	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Difficult concentration	<input type="checkbox"/> Digestion problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Feeling cold	<input type="checkbox"/> Feeling hot	<input type="checkbox"/> Foot pain
<input type="checkbox"/> Gastrointestinal disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Headache	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Hives
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Immune deficiency	<input type="checkbox"/> Itchiness
<input type="checkbox"/> Lupus	<input type="checkbox"/> Lyme's disease	<input type="checkbox"/> Menstrual disorder	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Numbness & tingling	<input type="checkbox"/> Palpitation (heart)	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Spinal misalignment	<input type="checkbox"/> Spinal fusion
<input type="checkbox"/> Skin problem	<input type="checkbox"/> Stress	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> T.M.J
Other (please specify) _____			

Briefly describe Family History:

- Mother's side: _____
- Father's side: _____

Women Only:

- Age of first period: ____ • Date of last period: _____ • Menstruation: Normal Irregular Painful
- Amount: Normal Excessive Little
- Color: Normal Dark Bright Clots
- Cramping: Yes No Mild Moderate Severe
- Discharge: Yes No • Between periods: Yes No
- Color: Normal Dark Bright Clots • PMS: Yes No
- History of Pregnancy:
Pregnancies Number: ____ Births: ____ Miscarriages: ____ C-Section: ____ Premature births: ____ Abortions: ____
- Hysterectomy: Year: _____ Hot Flashes: __ If yes, how many? ____ Night Sweats: __ If yes, how many? ____

Nutrition and Lifestyle:

- How is your appetite? _____ Do you have regular eating habits? Yes No If no, _____ times a day
- Do you crave certain foods? Yes: ____ No: ____ If yes, what foods do you crave? _____
- Do you smoke? Yes No • Do you drink? Yes No • How often _____, how many glasses _____
- Do you exercise regularly? Yes No If yes, What exercises do you do regularly? _____
- Do you sleep well? Yes No Do you get enough sleep at night? Yes No
- How many hours do you sleep at night? _____
- How often do you wake up during the night? _____ • The reason for waking _____
- Describe the quality of sleep you get _____
- Are you under a lot of stress? Yes No • Work related? Yes No
- How do you manage your stress? _____
- Do you get angry easily? Yes No Do you cry easily? Yes No
- Do you ever feel a lump in your throat? Yes No • Do you have lots of phlegm? Yes No
- How is your digestion? Good Bad Heartburn Acid reflux Cramping Bloating Stomach gas
- How is your urination? Normal Frequent Burning sensation • Color: Clear Yellow

- How are your bowel movements? Normal Constipated Diarrhea • Stool: Firm Loose
 Abdominal gas Abdominal cramping
- Do you feel thirsty? Yes No Dry mouth: Yes No Bitter taste: Yes No
- Do you drink lots of water? Yes No If yes, why? Thirsty Habit For health
- Do you have feelings of nausea? Yes No Do you vomit often? Yes No
- Do you have headaches? Yes No If yes, where? Forehead Sides Back Top Whole
- How is your energy level? High Medium Low

Do not write below this line:

(OFFICE USE ONLY)

Pulse:	Tongue:
Diagnosis:	
Treatment Principle:	
Acupuncture Points:	
Recommendation / Comments:	
Notes:	