GINKGO TREE ACUPUNCTURE
Acupuncture & Oriental Medicine
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New Patient Information

Welcome

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

Name _____ Today's Date _____

Street Address _____ Apt. _____

City _____State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____ Age _____ Gender _____

Occupation _____ Employer _____

Primary Physician:_____ Phone:_____

Referred by _____

Emergency Contact: Name _____ Phone _____

Main Complaint

Reason for visit today**:** _____

Other problems: _____

_____

_____

How long have you had the main complaint? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your: Sleep _____ Work _____ Other _____

Have you been given a diagnosis for these problems? _____

What other treatments have you tried and what were the outcomes?_____

_____

_____

Family Medical History- Complete for each family member, indicating any of the illnesses that they have had. Place an "X" in the appropriate box.

	self	mother	father	sibling	spouse	children
Cancer						
Diabetes						
Seizures						
High blood pressure						
Heart disease						
Allergies						
Stroke						
Asthma						
Hepatitis						
Other (describe)						

Personal Lifestyle Habits (how many, how often)

Cigarettes _____ Coffee/Tea _____ Alcohol (per week) _____

Recreational drugs _____

Vitamins & Herbs _____

_____

Dietary restrictions _____

Food cravings _____

Diet (typical day): Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

General

Height _____ Weight _____lbs

Most recent blood pressure reading ____/_____ Taken when?_____

Medicines

Prescription drugs you are currently taking: For what condition?

_____ _____

_____ _____

_____ _____

Over the counter medication currently taking: For what condition?

_____ _____

_____ _____

_____ _____

Allergies (medications/foods/chemicals/etc.):

_____
_____
_____

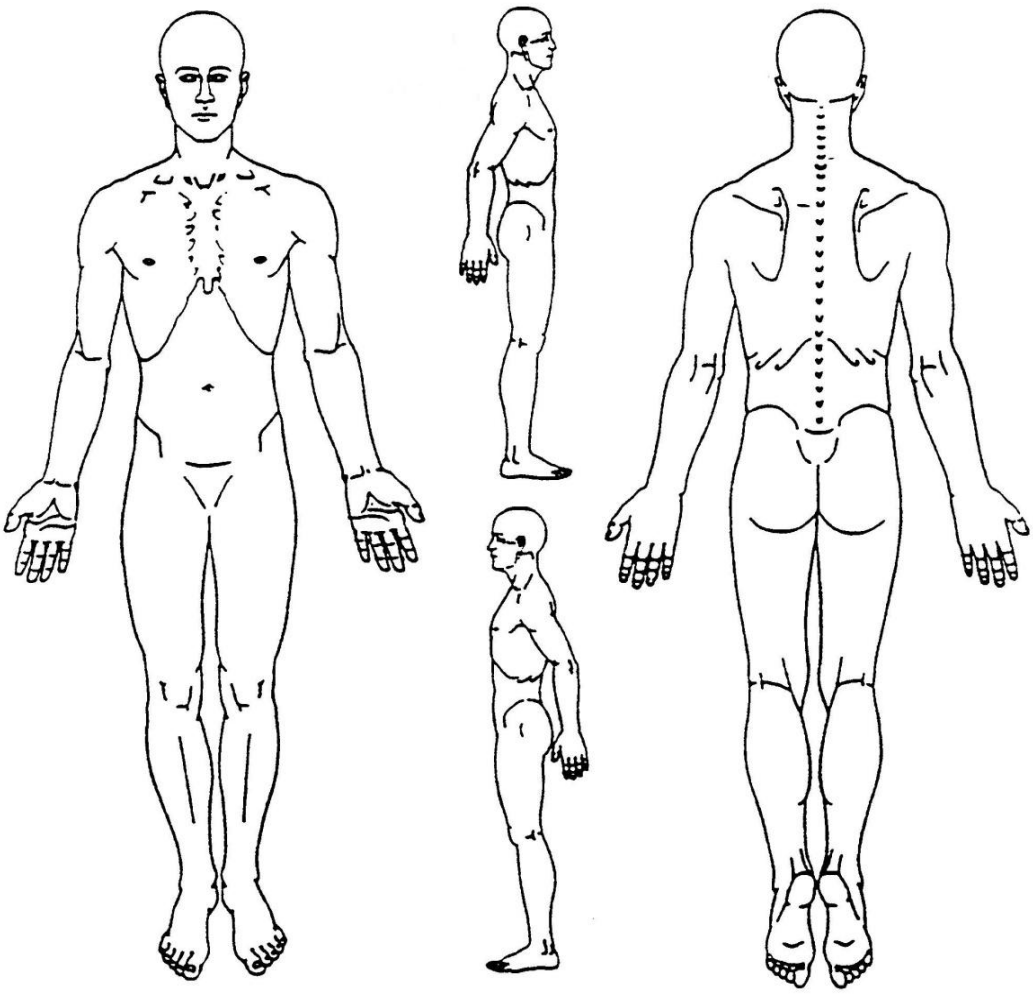
Please list any major surgeries/hospitalizations and approximate dates:

_____
_____
_____

Date of last physical examination: _____

Have you ever been treated with acupuncture or Chinese Medicine before? ___Yes ___No

Pain Diagram - Please mark any areas of pain on diagram



A- Aching
B-Burning
N- Numbness
P- Pins and Needles
S- Stabbing
O-Other

Please check any symptoms that you have experienced in the past or currently experience:

General
□ Poor appetite
□ Poor sleep/dreams
□ Fatigue/low energy
□ Fevers
□ Chills
□ Cravings
□ Bleed or bruise easily
□ Night sweating or hot flashes
□ Sweating easily
□ Usually feel cold
□ Usually feel warm
□ Weight loss/gain
□ High stress
□ Headaches
□ Migraines

Musculo-skeletal
□ Neck/shoulder pain
□ Weak/sore lower back
□ Arthritis
□ Muscle spasms/cramps
□ Restless leg syndrome
□ Muscle weakness
□ Pain with activity
□ Pain with weather changes
□ Muscle pain/tension
□ Joint pain
□ Limited range of motion
□ Areas of numbness
□ Heavy limbs

Mouth and throat
□ Recurrent sore throat
□ Copious saliva
□ Teeth grinding
□ Hoarseness
□ Sores on lips/tongue
□ Teeth/jaw clenching
□ Bleeding gums

Ears and Eyes
□ Hearing loss
□ Earaches
□ Ringing in the ears
□ Red/inflamed eyes
□ Eye floaters
□ Itchy eyes
□ Dry eyes
□ Blurry vision

Respiratory
□ Asthma
□ Bronchitis
□ Pneumonia
□ Chest congestion
□ Chest tightness
□ Shortness of breath
□ Difficulty inhale/exhale
□ Allergies
□ Cough __wet or __dry
□ Phlegm.. what color?_____

Digestive
□ Abdominal pain
□ Heartburn
□ Gas
□ Bloating
□ Belching
□ Indigestion
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Pain or cramps
□ Stomach pain
□ Poor appetite
□ Excessive hunger
□ Bad breath
□ Mucus in stool
□ Black stools/blood in stools
□ Strong smelling stools
□ Hemorrhoids
□ Itchy/burning anus
□ IBS
□ Crohns
□ Bowel movements: how often?
_____
□ Stools ___hard
___ firm
___ soft
___ loose (>2/day)

Mental/Emotional
□ Mood swings
□ Anxiety/nervousness
□ Depression
□ Poor concentration
□ Poor memory
□ Irritability
□ Quick temper
□ Sadness
□ Easily susceptible to stress

Skin & Hair
□ Rashes/hives
□ Eczema or psoriasis
□ Acne/boils
□ Redness skin
□ Itching
□ Hair loss
□ Dry skin/scalp
□ Weak nails
□ Lumps

Genito-Urinary
□ Difficulty urinating
□ Frequent urination
□ Poor bladder control
□ Night urination ___times
□ Dark urine
□ Kidney stones
□ Blood in urine
□ Urinary tract infections
□ Pain/burning urination
□ Decreased libido
□ Increased libido
□ Pain/itching of genitalia

Men only
□ Impotence
□ Premature ejaculation
□ Nocturnal emission
□ Lumps in testicles
□ Penile discharge

For Women Only:

	past	current		past	current
Irregular periods	□	□	Breast pain	□	□
Painful periods	□	□	Vaginal discharge	□	□
Bleeding between periods	□	□	Vaginal sores	□	□
Period clots	□	□	Hot flashes	□	□
Menstrual cramping	□	□	Night sweating	□	□

Age of first menses _____ duration of typical period _____
Duration of typical cycle _____ date of last PAP _____
Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____

Have you been through menopause? Age? _____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

Please list any other relevant information or issues you would like to discuss:

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out these forms. Please let us know if you have any questions or concerns.