Luke Acupuncture & Herbology Center 路 加 金 针 百 草 堂

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Patient Health Record

Name_____Birthday_____Sex_____
Marital Status_____Home Address_____
City_____State_____ZIP_____Fax_____
Phone_____(home); _____(work)_____(mobile)
Employer's address_____
Name & Phone of Physician_____
Name & Phone of Specialist_____
Primary Medical Insurance_____Other Medical Insurance_____
Referred by_____
Is this workers'compensation? Yes☐ No☐ Is this an auto accident? Yes☐ No☐

Do You Have Any of the Following Symptoms?

Fever or Heat Attacks	Yes☐ No☐	Easy Sweating	Yes☐ No☐
Cold Feeling or Chill Attacks	Yes☐ No☐	Depression	Yes☐ No☐
Fatigue	Yes☐ No☐	Pain	Yes☐ No☐
Abnormal Appetite	Yes☐ No☐	Insomnia	Yes☐ No☐
Diarrhea or Loose Stool	Yes☐ No☐	Lethargy	Yes☐ No☐
Abnormal Urination	Yes☐ No☐	Anxiety	Yes☐ No☐
Impotence (Man)	Yes☐ No☐	Constipation	Yes☐ No☐
		PMS (Woman)	Yes☐ No☐

Symptoms other than above_____

Reason for Visit Today_____

Medications_____

Past Medical History:
Disease (With Date):Cancer_____Heart Disease_____Seizure_____Diabetes____
Hypertension_____Thyroid Disease_____Hepatitis_____HIV/AIDS_____Other____
Skin Rashes_____***Allergies***:_____
If cancer patient:
Diagnosis_____Therapies received_____

Habits: Smoking____Alcohol____Coffee____Tea____Drugs_____Sugar____Other____
Family Medical History:
Cancer_____Diabetes_____Heart Disease_____Stroke_____
Hypertension_____Seizures_____Allergies_____Aloholism_____Other_____

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CONSENT FORM

Name_____

Address_____City_____State_____ZIP_____

I understand that acupuncture is performed by inserting needles through the skin, may be with the use of electrical stimulation or the application of heat, moxibustion and other techniques (i.e. cupping, manipulation) at acupuncture points.

I understand that certain adverse side effects may result from treatment. These could include but are not limited to slight bleeding, bruising or soreness at the insertion site. Fainting or syncope is rare but may occur to patient who is highly anxious, extremely fatigued or hungry.

I understand that there is no guarantee concerning the effect of treatment provided to me and I am free to discontinue treatment at any time.

I understand that this form of treatment is not a substitute for Western Medical treatment and that if I am under the care of a physician for a particular ailment or condition, I should continue my care until advised differently by my doctor.

_____ _____

Patient Signature (or Parent / Guardian) Date