Initial Visit Form

Patient Health History Form

Patient's Personal Information		
Patient's Name:		Date:
Address:		
City:	State:	Zip Code:
Telephone Number:	Work Number:	
Cell Number:	Email:	
Age: Date of Birth:	Gender:	
(Circle) Married Separated Divorced Widowed Single Have Children		
Occupation:		
Employer:		
Work Address:		
Have you ever seen a Practitioner of Chinese Medicine before? Yes / No		
How was your experience: Good Fair Poor		
How did you hear about my practice?		
Do you know anyone who has been seen by me before? Who?		
Were you referred? If Yes, by whom? Yes / No		
Primary Care Provider's Name and Contact Information:		

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Emergency Contact		
Next of Kin, or Person to reach in case of emergency:		
Relationship to Patient:	Phone:	
Address:		
City:	State:	Zip Code:

Responsible Party's Information				
Responsible Party:			Date of Birth:	
Relationship to Patient:	Self	Spouse	Other:	
Home Phone:		Work Phone:		
Occupation:				
Party's Address:				
City:	State:		Zip Code:	

Patient's Insurance Information	
Insurance Company:	
Insured Name:	Date of Birth:
Relationship:	
Insurance ID Number:	Group Number:
Office Use	
Maximum number of treatments per calendar year:	
Copay:	

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Questionnaire
Why did you choose to try Chinese Medicine?
What do you know about my approach?
What expectations do you have from this visit today?
What long-term expectations do you have from working with me as a practitioner of Chinese Medicine?

Questionnaire Cont.		
Name of your primary care physician:		
Phone number of primary care physician:		
Address of primary care physician:		
City:	State:	Zip Code:
Are you currently receiving health care?		
If yes, for what and from whom?		
If no, when was the last time you received health care?		
What was the reason for care?		
Do you currently have any contagious diseases? Yes / No / Not Sure		
If yes, please identify:		

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Lifestyle Questions		
Habit	**How Much?**	**How Often?**
Coffee or Tea		
Non-medical drugs (including recreational)		
Tobacco use		
Alcohol consumption		
Soda, or caffeinated drinks		
Drink water		
Exercise		
Excessive sitting		
Dine out		
Cook at home		
Watch Television		
Cell phone or internet use		
Stay up late		
Rate your stress level on an average week (0-10):		

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Main Health Concern
What is your main health concern?
How often does it affect you?
How intense does the condition become (0-10)?
How long does the condition last when it happens?

What improves the condition or makes it worse?	
Improves	**Worsens**

To what extent are the medications improving your quality of life or ability to get through the day?
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
What activities do the medications allow you to do that you could not do without the medications?

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Other Health Concerns				
Condition	**How Long?**	**How Often?**	**Duration?**	**Intensity (0-10)**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

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Medications / Prescriptions			
Medication	**For**	**Dosage**	**How Often**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

List of modalities or therapies tried: put an (X) on those that you found helpful		
1.	**Helped (X)**	**Did Not Help (X)**
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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Patient's Name:				Au:	Dx:

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Quality of life status: Place (X) when condition affects your quality of life	X
Frustration due to condition? No relief?	
Ability to work? Difficulty to perform your job?	
Daily routine? Use bathroom, eat, brush teeth, exercise? Etc...	
Relationship with friends and family? playing with kids or grandchildren, going out? Etc...	
Enjoying hobbies or special interests? bike riding, hiking, crafts? Etc...	
Sexual health or Ability to perform?	
Ability to sleep, feeling rested, ability to sit comfortably ?	
Yard work or Home maintenance?	
Does this impact your mental health?	
Would you be enjoying something more if it wasn't for this condition ? (If yes place an **X**.)	

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Health History		
How was your childhood health?		
Any hospital stays, surgeries, procedures?		
Any recent tests?		
Any car accidents, falls, or traumatic injuries?		
Indicate any significant illnesses you or blood relative have had:		
Illness	**You**	**Relative**
Cancer		
Hepatitis		
High Blood Pressure		
Rheumatism (Arthritis)		
Infectious Diseases		
STDs: Gonorrhea, Syphilis, AIDS, HPV, Chlamydia, Herpes		
Diabetes		
Heart Disease (Specify)		
Seizures		
Emotional Disorders		
Tuberculosis		
Thyroid Conditions (Specify)		
Autoimmune Conditions (MS, Lupus, Psoriasis)		
Other:		
Other:		
Other:		

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Do you have any known allergies? If yes, please list:
Do you have any medical devices, (Pacemaker, screws, etc.)? If, yes please list:

Male Health Questionnaire				
Date of last prostate exam:		PSA results:	Manual Prostate exam results:	
Lab results:				
Frequency of urination:		Day:	Night:	
Color of urine:		Clear: **Yes / No**	Cloudy: **Yes / No**	Odor: **Yes / No**
Prostate Related Symptoms: (Place an X)				
Dribbling	Prostate problems	Delayed stream	Groin or testicle pain	Burning urination
Incontinence	Rectal dysfunction	Increased libido	Decreased lbido	Retention of urine
Back pain	Premature ejaculation	impotence	Fever and chills	Other:

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Female Health Questionnaire			
Age of 1st period:	Are your pregnant: **YES / NO**		Number of pregnancies:
Age of last period:	# of live births:		Number of miscarriages:
Number of days of flow:	Number of days between periods:		Last Gyno exam date:
Pap smear:	Date of recent mammogram: Results:		
Date of recent bone density exam: Results:			
Menstruation Quality			
Clots: **YES / NO**	Color of Flow:		Irritable depressed No Change
Do you suffer from pain before, during, or after menstruation? **YES / NO** Please indicate when: (**B**)efore, (**D**)uring, or (**A**)fter			
Cramping:	Dull:	Burning:	Consistent:
Stabbing:	Aching:	Bloating:	Intermittent:
Bearing down sensation:	Spasming:		
Other Symptoms Related to Menstruation: (Place an X)			
Discharge:	Vaginal Dryness:	Headaches:	Nausea:
Constipation:	Diarrhea:	Swollen breasts:	Mood swings:
Increased appetite:	Hot flashes:	Night Sweats:	Poor appetite:
Insomnia:	Increased libido:	Decreased libido	Fatigue or listlessness:
Average number of pads used per day: **DAY 1:** **DAY 2:** **DAY 3:** **DAY 4:** **DAY5:** **DAY X:**			
Have you ever been diagnosed with: Fibroids Fibrocystic breasts Endometriosis Ovarian cysts PID Other:			