New Patient Form: Traditional Chinese Medicine / Acupuncture

Name: _____ Date: _____

Address: _____

Home Tel: _____ Cell: _____ Email: _____

Date of Birth: _____

Person to contact in case of emergency: _____ Phone: _____

Relationship: _____

How were you referred to us?: _____

Sex: ___ Male ___ Female Age _____ Height _____ Weight _____

Your Employer: _____
Type of Work Performed: _____

HEALTH HISTORY
Major area(s) of concern:

_____

Other treatment(s) received for these concern(s):

_____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc):

_____

Are there others in your family with the same condition?

_____

Other health concerns/complaints?

_____

Is this related to: [ ] A Work Injury? [ ] A Car Accident? Date of Injury _____

Medications you now take:

_____ _____ _____

_____ _____ _____

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Vitamins, supplements, herbs, remedies you now take:

_____ _____ _____

_____ _____ _____

Have you previously sought other complementary care? _____ Please check which one(s)
[ ] Naturopathy [ ] Shiatsu [ ] Massage/Body Work [ ] Chiropractic [ ] Acupuncture [ ] Osteopathy

PAST HEALTH HISTORY (include dates)
Major illnesses

_____

Major surgeries

_____

Other significant trauma_____
Have you been treated for any health condition in the past year? [ ] Yes [ ] No
If yes, please explain:_____

Allergies (drugs, chemicals, foods) _____
Do you smoke? [ ] Yes [ ] No

FAMILY MEDICAL HISTORY

[ ] Allergies [ ] Alcoholism [ ] Asthma [ ] Cancer [ ] Diabetes [ ] Stroke

[ ] Heart Disease [ ] High Cholesterol [ ] High Blood Pressure

[ ] Back Problems (describe) _____

[ ] Other (describe) _____

Check any of the following diseases and conditions you have or have had:

[ ] Alcoholism [ ] Anemia [ ] Appendicitis [ ] Arthritis [ ] Cancer [ ] Chicken Pox [ ] Diabetes [ ] Epilepsy [ ] Goiter [ ] Heart Disease	[ ] High Cholesterol [ ] Influenza [ ] Malaria [ ] Measles [ ] Mental Disorder [ ] Mononucleosis [ ] Mumps [ ] Pleurisy [ ] Pneumonia [ ] Rheumatic Fever	[ ] Tuberculosis [ ] Tattoos [ ] Sexually Transmitted Disease [ ] Whooping CougH [ ] Dental work (including silver fillings

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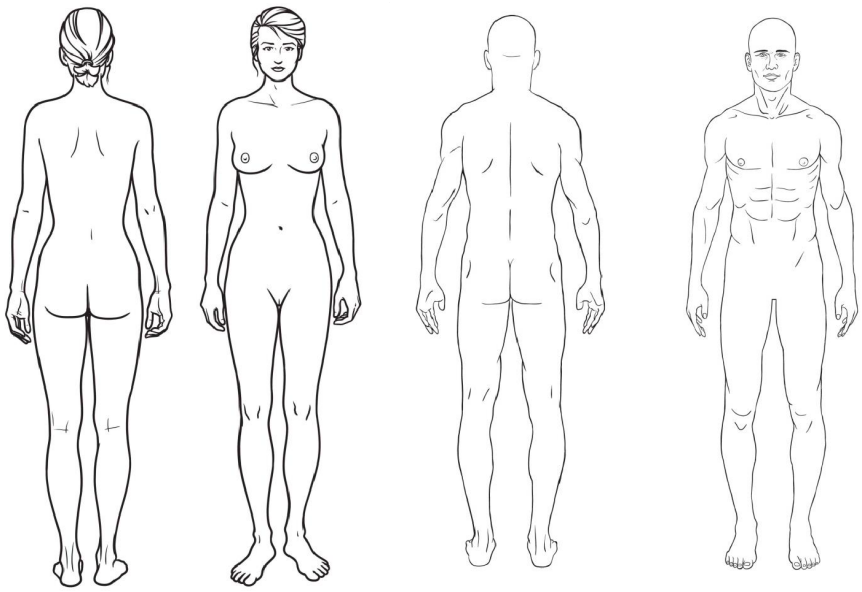
PLEASE MARK AREAS OF CONCERN

Musculo-Skeletal
[ ] Low Back Pain
[ ] Pain Between Shoulders
[ ] Neck Pain
[ ] Arm Pain
[ ] Joint Pain/Stiffness
[ ] Walking Problems
[ ] Pained/Clicking Jaw

Nervous System
[ ] Numbness
[ ] Dizziness
[ ] Forgetfulness
[ ] Confusion/Depression
[ ] Fainting
[ ] Convulsions
[ ] Cold/Tingling Extremities



Cardio-Vascular [ ] Chest Pain [ ] Short Breath [ ] Blood Pressure Problems [ ] Irregular Heartbeat [ ] Lung Problems/Congestion [ ] Varicose Veins [ ] Ankle Swelling Eye, Ear, Nose, Throat [ ] Vision Problems [ ] Dental Problems [ ] Sore Throat [ ] Hearing Difficulty [ ] Ear Aches [ ] Stuffed Nose [ ] Ringing in Ears Genito-Urinary [ ] Urinary Tract Infection [ ] Painful/Excessive Urination [ ] Blood in Urine	Gastro-Intestinal [ ] Poor/Excessive Appetite [ ] Excessive Thirst [ ] Frequent Nausea [ ] Diarrhea [ ] Constipation [ ] Hemorrhoids [ ] Liver Trouble [ ] Gall Bladder Problems [ ] Abdominal Cramps [ ] Gas/Bloating After Meals [ ] Heartburn/Indigestion [ ] Black/Bloody Stool [ ] Colitis/Irritable Bowel [ ] Frequency of Bowel Movements Skin [ ] Rash [ ] Hives [ ] Eczema [ ] Psoriasis [ ] Itch Without Eruption	General [ ] Allergies (Seasonal) [ ] Loss of Sleep [ ] Fever [ ] Headache [ ] Migraines Male Only [ ] Prostate [ ] Swollen/Shrunken Testes [ ] Sexual Dysfunction Any other Male Difficulties?

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Female Only [ ] Menstrual Irregularity [ ] Menstrual Cramping [ ] Vaginal Pain/Infections [ ] Breast Pain/Lumps (Right) [ ] Beast Pain/Lumps (Left) _____Age Menstruation Started _____ Days Between Cycle _____ Usual Days of Flow _____ Maximum Pads in Day _____ Date of Last Period	Any recent tendency to [ ] Heavier Periods [ ] Longer Periods [ ] Scantier Periods [ ] Quality of Blood: [ ] Bright Red [ ] Dark [ ] Clots [ ] Premenstrual Tension [ ] Discharge Between Periods	_____ Number of Pregnancies _____ Number of Living Babies _____ Number of D & C _____ Number of Abortions _____ Number of Miscarriages [ ] Cesarean(s) [ ] Hysterectomy(s) _____ Date of Last PAP Smear _____ Date of Last Mammogram _____ Method of Contraception ____Difficulty Getting Pregnant Any other Feminine Difficulties

I have answered the above questions to the best of my knowledge.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform ZAFIRO MED of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and professional from liability and assume full responsibility thereof.

_____

Client Signature Printed Name Date

_____

Witness Signature Printed Name Date

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