Tallahassee Chinese Medicine and Community Acupuncture

Patient Name: _____ Date: _____
Address: _____
Call/Text: _____ Occupation: _____
Email: _____
Birthdate: _____ Marital Status: _____ Age: _____ M / F
Emergency Contact: _____ Referred by: _____

Reason for visit: 1/ _____
2/ _____
3/ _____

How long have you had this condition? _____ Getting worse? Y / N
Does it bother you during: Sleep__ Work__ Other__(what?) _____
What seemed to be the initial cause? _____
What seems to make it better? _____
What seems to make it worse? _____

Are you under the care of a physician now? Y / N How long? _____
Who is your physician? _____ Phone: _____
Current medications: _____
Current supplements: _____

Family Medical History:(Grandparents, Mother, Father, Siblings)

__Allergies:(list) _____
__Arteriosclerosis __Diabetes __Heart Disease __Obesity __Stroke __Arthritis
__Asthma __Cancer __Addiction __Seizures __Ulcers __Other _____

Your Past Medical History:(Check any conditions you currently have or have had in the past)

__Aids/HIV	__Emphysema	__Multiple Sclerosis	__Surgery 1/ _____
__Alcoholism	__Epilepsy	__Mumps	2/ _____
__Allergies	__Goiter	__Pacemaker	3/ _____
__Appendicitis	__Gout	__Pneumonia	__Thyroid Disorders
__Arteriosclerosis	__Heart Disease	__Polio	__Trauma (fall, car accident,etc.)
__Asthma	__Hepatitis	__Rheumatic Fever	__Tuberculosis
__Cancer	__Herpes	__Scarlet Fever	__Ulcers
__Chicken Pox	__Hypertension	__Seizures	__Venereal Disease (STD's)
__Diabetes	__Measles	__Stroke	__Other: _____

Your Diet:

Appetite: __Low __High Cravings? _____ How many meals/day? _____
__Coffee __Tea __Soft Drinks __Ice in drinks? __Cups of water/day __Vegan

Your Lifestyle:

__Marijuana __Stress __Alcohol Regular Exercise? Y / N
__Job Hazards __Drugs __Tobacco Type_____Frequency_____

General Symptoms:

__Poor appetite	__Poor sleep	__Heavy arms/legs	__Chills
__Excessive hunger	__Difficult waking up	__Cold hands or feet	__Night sweats
__Strongly like cold drinks	__Excessive dreaming	__Poor circulation	__Sweat easily
__Strongly like hot drinks	__Fatigue	__Shortness of breath	__Muscle cramping
__Recent weight loss/gain	__Bleed/bruise easily	__Fever	__Vertigo/Dizziness

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Head, Eyes, Ears, Nose, Throat:

__Glasses/Contacts	__Night blindness	__Tongue/Lip sores	__Sore throat
__Eye strain	__Glaucoma	__Dry mouth	__Lump in throat
__Eye pain	__Cataracts	__Excessive saliva	__Nose bleeds
__Red eyes	__Teeth problems	__Sinus problems	__Ringing in ears
__Itchy eyes	__Grinding teeth	__Excessive mucus	__Poor hearing
__Spots in eyes	__TMJ	Color of mucus:	__Earaches
__Poor vision	__Facial pain		__Headaches
__Blurred vision	__Gum problems	_____	__Migraines

Respiratory:

__Difficulty breathing when lying down	__Tight chest	__Cough
__Shortness of breath	__Asthma/wheezing	Wet or Dry?_____
	__Coughing blood	Thick or thin mucus?

CardioVascular:

__High blood pressure	__Fainting	__Low blood pressure	__Chest pain/Tight	__Tachycardia
__Blood clots	__DysAutonomia/P.O.T.S.		__Diffucult breathing	__Heart Palpitations

GastroIntestinal:

__Nausea	__Diarrhea	__Cramping	Bowel movements:
__Vomiting	__Constipation	__Itchy anus	Color: _____
__Acid reflux	__Laxative use	__Anal fissures	Frequency: _____
__Gas	__Black stools	__Rectal pain	Texture/Form: _____
__Bloating	__Bloody stools	__Hemorrhoid	Strong odor: Y / N
__Hiccup	__Mucus in stools	__Food Allergy (list)	Does your bowel movement wake
__Bad breath	__Undigested food	_____	you in the morning? Y / N

MusculSkeletal:

__Neck/shoulder pain	__Upper back pain	__Joint pain	__Muscle cramping
__Muscle pain	__Lower back pain	__Rib pain	__Limited range of motion

Skin and Hair:

__Rashes	__Eczema	__Psoriasis	__Hair loss	Other hair or skin problems:
__Hives	__Itching	__Ulcerations	__Dry skin	_____
__Acne	__Fungus	__Dandruff	__Oily skin	_____

NeuroPsychological:

		__Anxiety	__PTSD
__Numbness	__Poor memory	__High Stress	__Abuse survivor
__Tics	__Depression	__Irritability	__Considered suicide

Genito-Urinary:

__Pain on urination	__Blood in urine	__Bedwetting	__Decreased libido
__Frequent urination	__Incontinence	__Wake to urinate	__Increased libido
__Urgent urination	__Incomplete urination		__Kidney stone
__Impotence	__Premature ejaculation		__Nocturnal emission

Gynecology:

Age menses began: _____		__PMS	__Menopause/Age began:_____
Length of cycle: _____		__Clots	# of pregnancies _____
__Breast lumps	__Vaginal sores	__Cramping	# of births _____
__Irregular periods	__Vaginal odor	__Tiredness	Date of last PAP: _____
__Painful periods	__Vaginal discharge(color)	_____	Date last menses: _____

All statements are true and correct to the best of my knowledge. Please sign and date below.

Patient Signature: _____ **Date:** _____

Tallahassee Chinese Medicine and Community Acupuncture

Welcome to Tallahassee Chinese Medicine and Community Acupuncture!

This letter is to welcome you into the world of Chinese medicine. We are honored to assist you in your journey towards optimal health and wellness. For over the last three thousand five hundred years, Traditional Chinese Medicine has established itself as one of the major medical disciplines of the world and now, it is becoming more accessible and understood in the west.

At Tallahassee Chinese Medicine and Community Acupuncture, we integrate ancient wisdom with modern medical practice. With compassionate, comprehensive, and caring healthcare set in a professional, yet tranquil environment, we will strive to achieve all of your health and wellness goals while relaxing your body, mind, and spirit.

Thank you for choosing us as your acupuncture and oriental medicine health care provider. As an added service to you for becoming a patient with us, you can email any questions you may have regarding Acupuncture, HeartMath, Herbs, or any other topic related to your treatment(s) to the email address below. We look forward to meeting you at your scheduled appointment!

Sincerely,