



PATIENT INFORMATION (ADULT MALE)

Please provide as complete information as possible, even if you do not feel certain questions pertain to your present condition. All the information you provide is confidential and is useful in determining the best treatment plan for you.

name: _____ date of birth: _____

age: _____ gender (please circle): m or f occupation: _____

street address: _____ home phone: _____

city, state, zip: _____ cell phone: _____

email: _____ work phone: _____

single married divorced separated widowed partnership living with same sex relationship

emergency contact name: _____ relationship to you: _____

address: _____ home phone: _____

cell phone: _____ work phone: _____

have you had acupuncture before?: _____

how did you hear of us? may we thank someone for referring you?: _____

HEALTH HISTORY

what are your most important health concerns? please list in order of importance:

1. _____ date of onset: _____

2. _____ date of onset: _____

3. _____ date of onset: _____

4. _____ date of onset: _____

5. _____ date of onset: _____

are you under a physician's care for any of your health concerns? (please describe if appropriate): _____

have you sought any other treatment(s) for any of your health concerns? (please describe): _____

is there anything that improves or aggravates your condition?: _____

have you had any blood tests, x-rays, CT scans, MRIs, EKGs, or other tests related to your health concerns within the past year? please list & describe the results to the best of your knowledge and/or memory:



date of last physical exam: _____ name of physician: _____ physician's phone: _____

please list any hospitalizations and/or surgeries (not including those related to childbirth):

hospitalization / surgery	date	reason

please list any injuries and/or accidents:

accident/injury	date	relation to any health concerns

please indicate if you are taking any of the following:

- blood thinners (warfarin, coumadin, etc.)
- diet pills (diuretics, appetite suppressants, etc.)
- pain relievers (Tylenol, aspirin, etc.)
- cortisone or other steroids
- thyroid medication
- tranquilizers/sedatives
- sleeping aids
- laxatives
- antacids (tums, etc.)

please list all prescription and over-the-counter medications you are currently taking:

name	dosage	reason for taking	date began taking

please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc.):

name	dosage	reason for taking	date began taking



approximately how many courses of antibiotics have you taken over the past 10 years? _____

Please mark an x in the appropriate column (leave blank if you do not experience the symptom):

	occasional	frequent		occasional	frequent
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty in making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		



do you have a bowel movement every day?: _____ #per day/week?: _____

please describe any allergies and/or food sensitivities: _____

LIFESTYLE HISTORY

height: _____ weight: _____ weight one year ago: _____ maximum weight: _____ when?: _____

do you exercise?: _____ how many times a week? _____

what type of exercise?: _____

do you drink coffee/black tea?: _____ # 8 oz cups per day/week?: _____

do you drink soda?: _____ is it caffeinated? _____ # 12 oz glasses per day/week?: _____

how much water do you drink per day?: _____

please describe your typical diet:

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

meals per day: _____ do you eat at regular times each day?: _____

#snacks per day: _____ how often do you eat out (or order in)?: _____

are you vegetarian, vegan, kosher? are there other restrictions to your diet?: _____

do you experience any gas, burping, bloating, acid reflux or other digestive symptoms after eating any foods?:

Do you use tobacco?: _____ how many times per day/week?: _____

have you used tobacco in the past?: _____ when did you stop?: _____

do you drink alcoholic beverages?: _____ how many drinks do you have per day/week?: _____

do you use recreational drugs?: _____ how many times per day/week/month/year?: _____



have you been treated for drug/alcohol addiction?: _____

hours you sleep per night: _____ time you go to bed: _____ wake up?: _____

do you sleep well?: _____ do you awake feeling rested?: _____

what is your average stress level (1 is lowest, 10 is highest) please circle: 1 2 3 4 5 6 7 8 9 10

what is your average energy level (1 is lowest, 10 is highest) please circle: 1 2 3 4 5 6 7 8 9 10

at what time of day is your energy typically at its best?: _____ at its worst?: _____

how do you feel about the following areas of your life?

	great	good	fair	poor	bad
significant other					
family relations					
friendships					
living arrangements					
self image					
sex					
work					
vacations/time off					
exercise					
spirituality					

how much change are you willing to/able to make at this time to improve your health (please circle)

minimal

some

complete

FAMILY HISTORY

father's current age: _____ please circle: good health poor health deceased (cause & age: _____)

mother's current age: _____ please circle: good health poor health deceased (cause & age: _____)

please indicate whether you or any family member has, or has had in the past, any of the following conditions:

disorder/illness	which family member (include yourself) give important details	date	frequency (if applicable)
alcoholism/addictions			
allergies/asthma			
alzheimer's disease			
anemia			
arthritis			
autoimmune disorders			
birth defects			
bleeding disorders			
blood clots			
cancer (specify type)			



disorder/illness	which family member (include yourself) give important details	date	frequency (if applicable)
depression/anxiety			
diabetes			
epilepsy			
gallbladder problems			
glaucoma			
heart disease			
heart murmurs			
hepatitis			
high cholesterol			
high blood pressure			
HIV/AIDS			
infectious disease			
kidney disease			
kidney stones			
mental illness			
osteoporosis			
pacemaker or defibrillator			
shingles			
stroke			
tuberculosis			
urinary tract infections			
yeast infections			

FOR MEN

date of last prostate exam: _____ psa results: _____

lab results/diagnosis: _____

frequency of urination – daytime: _____ night time: _____

color of urine: _____ is urine clear or murky?: _____ is there any odor?: _____

	occasional	frequent		occasional	frequent
back pain			increased libido		
delayed urine stream			decreased libido		
dribbling urine			discharge/sores		
incontinence			premature ejaculation		
retention of urine			inability to ejaculate		
testicular pain			difficulty achieving erection		
testicular masses			difficulty sustaining erection		
hernia			impaired fertility		
groin pain			rectal dysfunction		



are you sexually active?: _____ STD's?: _____

is there anything else you would like us to know?: _____

thank you for taking the time to answer these questions. we appreciate your time and effort.
i certify that the information I have provided above is correct and accurate to the best of my knowledge.

Patient's (or Patient Representative's) Signature

Patient's Name

Date

Patient Representative's Name

Representative's relationship to patient