MIDDLE PATH ACUPUNCTURE CLINIC

2517 Mission Street   Suite 10   S.F., CA 94110

PERSONAL INFORMATION

Name: ____ Today's Date: ________

Address: ____

____

Telephone: Home (___)____________Work (___)___________ Cell (___)___________

Fax: (___)____________   Email: ______________________________

Date of Birth: __________________   Age: ____________________

Social Security #: _____–______–______

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ______________

Emergency Contact: ____

Contact Telephone #: (___)____________ Relationship: ________________________

Living situation: ____

EMPLOYMENT

Employment Status:

Full Time ☐ Part Time ☐ Retired ☐ Unemployed: long-term ☐ temporarily ☐

Occupation: ____

Employer: ____

Address: ____

HEALTH CARE & INSURANCE

Physician's Name: ______________________________ Telephone: (___)___________

Address: ____

Date of Last Visit: ______________ Date of Injury or Onset of Illness: ______________

Medical Insurance Status:

Private Insurance ☐ Medi-Cal ☐ Worker's Comp ☐ Uninsured ☐ Other: _________

Primary Insurance: ___________________________ Telephone #: (___)____________

Billing Address: ____

Policy Holder's Name: _____________________________ Relationship: ___________

Policy #/ ID #: _______________________________ Group #: __________________

MIDDLE PATH ACUPUNCTURE CLINIC

Patient Name: ____ Date:__________

FAMILY HEALTH HISTORY (Place an X in the appropriate box for each individual)

	Self	Mother	Father	Brother	Sister	Grandparent	Children
Allergies							
Diabetes							
Cancer/ Tumors							
Seizures							
Tuberculosis							
Heart Disease							
Stroke							
Depression/ Mental Illness							
Drug Abuse							
GI Disorder							
Kidney Disease							
High Blood Pressure							
Anemia/Blood Disorder							
Skin Disorder							
Thyroid Disorder							
Other							
Age at Death							

MAJOR HOSPITALIZATIONS, X-RAYS, CAT SCANS, MRI'S (If you have ever been hospitalized for any serious medical illness, procedures or surgical operations)

Date	Operation, Procedure or Illness	Name of Hospital	City & State

Do you have any infectious diseases? Please explain: ________________________________

____

____

MIDDLE PATH ACUPUNCTURE CLINIC

Patient Name: ____ Date:__________

MEDICINES (Place an X in the box of all medicines you are currently taking and how much you are taking each day)

☐ Aspirin	☐ Tylenol	☐ Ibuprofen
☐ Antacids	☐ Laxatives	☐ Diet Pills
☐ Allergy Pills	☐ Diet Pills	☐ Oral Contraceptives
☐ Blood Thinning Pills	☐ Tranquilizers	☐ Sleeping Pills
☐ Blood Pressure Pills	☐ Cold Medicine	☐ Prescription Pain Pills
☐ Cholesterol Pills	☐ Diuretic Pills	☐ Anticonvulsant Pills

☐ Other: ____
____

Vitamins: ____
Supplements: ____

ALLERGIES (List ALL known allergies and any hypersensitivities to foods or drugs)
____
____

HABITS (Check those which apply to you now or in the past. Circle day or week)

Coffee	☐ Yes	☐ No	Cups each day/week______	Age began___	Age quit___
Tea	☐ Yes	☐ No	Cups each day/week______	Age began___	Age quit___
Caffeinated Soda	☐ Yes	☐ No	Cups each day/week______	Age began___	Age quit___
Tobacco	☐ Yes	☐ No	# Cigarettes/day________	Age began___	Age quit___
Marijuana	☐ Yes	☐ No	Use each day/week________	Age began___	Age quit___
Alcohol	☐ Yes	☐ No	# Drinks each day/week_____	Age began___	Age quit__
Cocaine/Crack	☐ Yes	☐ No	Use each day/week_______	Age began___	Age quit___
Heroine	☐ Yes	☐ No	Use each day/week________	Age began___	Age quit___

LIFESTYLE

Do you eat 3 meals per day? Y N
What do you typically eat? Morning:____
Afternoon:____
Evening: ____
Do you exercise regularly? ____
How many non-carbonated, non-caffeinated beverages do you drink each day? ___________
How many hours a night do you sleep? __________________ Do you wake rested? Y N
How many hours a week do you watch television? _________________

MIDDLE PATH ACUPUNCTURE CLINIC

Patient Name: ______________________________________ Date:____________

GENERAL

past current
- ☐ ☐ Low appetite
- ☐ ☐ Excessive appetite
- ☐ ☐ Low energy
- ☐ ☐ Fatigue
- ☐ ☐ Localized weakness
- ☐ ☐ Fevers
- ☐ ☐ Chills
- ☐ ☐ Night sweats
- ☐ ☐ Sweat easily
- ☐ ☐ Difficulty falling asleep
- ☐ ☐ Difficulty waking up
- ☐ ☐ Lack of thirst
- ☐ ☐ Strong thirst
- ☐ ☐ Other: ___________

CARDIOVASCULAR

past current
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Blood Clots
- ☐ ☐ Palpitations/ Heart Fluttering
- ☐ ☐ Chest Pain
- ☐ ☐ Irregular Heart Beat
- ☐ ☐ Phlebitis
- ☐ ☐ Fainting
- ☐ ☐ Cold hands/feet
- ☐ ☐ Swelling of hands/feet
- ☐ ☐ Heart Murmur
- ☐ ☐ Other: ________________

GASTRO-INTESTINAL

past current
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Belching
- ☐ ☐ Abdominal Pain/Cramps
- ☐ ☐ Indigestion
- ☐ ☐ Hemorrhoids
- ☐ ☐ Rectal pain
- ☐ ☐ Gas/Flatulence
- ☐ ☐ Gallbladder or Liver disease
- ☐ ☐ Heart burn/Acid Reflux
- ☐ ☐ Feeling that bowels do not empty completely
- ☐ ☐ Other: ________________

GENITO-URINARY

past current
- ☐ ☐ Kidney stones
- ☐ ☐ Painful urination
- ☐ ☐ Frequent urination
- ☐ ☐ Blood in urine
- ☐ ☐ Cloudy urine
- ☐ ☐ Difficulty in urination
- ☐ ☐ Urgency to urinate
- ☐ ☐ Urinary incontinence
- ☐ ☐ Other: ___________________

RESPIRATORY

past current
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ COPD
- ☐ ☐ Cough
- ☐ ☐ Coughing blood
- ☐ ☐ Coughing phlegm
- ☐ ☐ Pneumonia
- ☐ ☐ Chest congestion
- ☐ ☐ Frequently catch colds
- ☐ ☐ Other: _____________

NEUROLOGICAL

past current
- ☐ ☐ Seizures
- ☐ ☐ Tremors
- ☐ ☐ Numb/tingling in limbs
- ☐ ☐ Pain
- ☐ ☐ Paralysis
- ☐ ☐ Fainting
- ☐ ☐ Concussion
- ☐ ☐ Other: __________________

HEAD AND NECK

past current
- ☐ ☐ Dizziness
- ☐ ☐ Neck stiffness
- ☐ ☐ Enlarged lymph glands
- ☐ ☐ Headaches
- ☐ ☐ Concussion/trauma to head
- ☐ ☐ Other: ____________________

EYES

past current
- ☐ ☐ Blurred vision
- ☐ ☐ Visual changes
- ☐ ☐ Lacrimation/tearing
- ☐ ☐ Eye pain
- ☐ ☐ Poor night vision
- ☐ ☐ See spots
- ☐ ☐ Cataracts
- ☐ ☐ Eyeglasses/contact lenses

NOSE, THROAT & MOUTH

past current
- ☐ ☐ Nose bleeds
- ☐ ☐ Frequent sinus infections
- ☐ ☐ Recurring sore throats
- ☐ ☐ Grinding teeth
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Goiter
- ☐ ☐ Other: _____________________

EARS

past current
- ☐ ☐ Recurring infections
- ☐ ☐ Ringing
- ☐ ☐ Itching
- ☐ ☐ Decreased hearing
- ☐ ☐ Other: ____________________

MALE

past current
- ☐ ☐ Pain/itching of genitalia
- ☐ ☐ Genital lesions/discharge
- ☐ ☐ Impotence
- ☐ ☐ Erectile difficulty
- ☐ ☐ Premature ejaculation
- ☐ ☐ Lumps on testicles
- ☐ ☐ Low libido
- ☐ ☐ Other: _____________________

FEMALE

past current
- ☐ ☐ Frequent UTI
- ☐ ☐ Frequent vaginal infection
- ☐ ☐ Pain/itching of genitalia
- ☐ ☐ Genital lesions/discharge
- ☐ ☐ Pelvic Inflammatory Disease
- ☐ ☐ Endometriosis
- ☐ ☐ Irregular periods
- ☐ ☐ Abnormal bleeding
- ☐ ☐ Painful menstrual periods
- ☐ ☐ PMS
- ☐ ☐ Menopausal syndrome
- ☐ ☐ Breast lumps
- ☐ ☐ Infertility
- ☐ ☐ Low libido
- ☐ ☐ Other: ____________________________

INFECTION SCREENINGS

	past	current status
HIV	☐	☐ positive ☐ negative
TB	☐	☐ positive ☐ negative
Hepatitis	☐	☐ positive ☐ negative Type:
Gonorrhea	☐	☐ positive ☐ negative
Chlamydia	☐	☐ positive ☐ negative
Syphilis	☐	☐ positive ☐ negative
Genital warts	☐	☐ positive ☐ negative
Herpes	☐	☐ positive ☐negative Type:

MIDDLE PATH ACUPUNCTURE CLINIC

Patient Name: ____ Date: _______________

Are you presently being treated for a medical condition?
____

Have you ever had an acupuncture treatment? When and for what reason?
____

Please identify the health concerns that have brought you to Middle Path Acupuncture Clinic in order of importance below:

Condition **Past Treatment & Results**

a. ________________________________ ____

____

How does this condition affect you?____

b. _________________________________ ____

____

How does this condition affect you? ____

c. _________________________________ ____

____

How does this condition affect you? ____

d. _________________________________ ____

____

How does this condition affect you? ____