MIDDLE PATH ACUPUNCTURE CLINIC

220 Montgomery Street, Suite 477 San Francisco, CA 94104

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__
Street drugs	□ Yes □ No	Use each day/week_____ Age began___ Age quit___
Heroin/opioids	□ 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? _____