

DR. HEIDI KAO, DAOM LAC

ACUPUNCTURE · HERBAL MEDICINE · TUI NA

PERSONAL INFORMATION

PATIENT NAME: LAST	FIRST	MIDDLE
ADDRESS:		ZIP:
CONTACT INFORMATION: HOME:		WORK:
()	()	()
EMAIL:		
DATE OF BIRTH:	AGE:	SOCIAL SECURITY NUMBER:
EMERGENCY CONTACT INFORMATION: NAME:		PHONE NUMBER: ()
RELATIONSHIP:		
STATUS: <input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED
<input type="checkbox"/> WIDOWED	<input type="checkbox"/> OTHER _____	
REFERRED BY: NAME:	TELEPHONE CONTACT:	

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> STUDENT				
OCCUPATION:				
EMPLOYER NAME:		EMPLOYER TELEPHONE:()		
EMPLOYER ADDRESS:		CITY:	ZIP:	

PRIMARY HEALTHCARE PROVIDER

PRIMARY PHYSICIAN:	TELEPHONE:()
PHYSICIAN ADDRESS:	
DATE OF LAST VISIT:	DATE OF INJURY / ONSET OF ILLNESS:

INSURANCE/SUPERBILL INFORMATION

INSURANCE COMPANY:	POLICY HOLDER'S NAME:
POLICY NAME (IF APPLICABLE):	EMPLOYER NAME (IF APPLICABLE):
POLICY NUMBER:	
INSURANCE COMPANY TELEPHONE: ()	INSURANCE COMPANY FAX.: ()

ILLNESS AND TREATMENT INFORMATION

HAVE YOU EVER HAD AN ACUPUNCTURE TREATMENT? <input type="checkbox"/> NO <input type="checkbox"/> YES
WHEN AND FOR WHAT REASON?
ARE YOU PRESENTLY BEING TREATED FOR A MEDICAL CONDITION? PLEASE DESCRIBE. <input type="checkbox"/> NO <input type="checkbox"/> YES
PLEASE BRIEFLY DESCRIBE ANY CHRONIC PAIN?
WHAT HEALTH ISSUE DO YOU WANT TREATED? PLEASE DESCRIBE AS FULLY AS POSSIBLE.
HAVE YOU BEEN USING OTHER MEDICAL TREATMENTS FOR RELIEF OF THIS ISSUE? PLEASE DESCRIBE. <input type="checkbox"/> NO <input type="checkbox"/> YES
DO YOU HAVE OTHER HEALTH CONCERNS? PLEASE DESCRIBE. <input type="checkbox"/> NO <input type="checkbox"/> YES

FAMILY HISTORY INFORMATION: PLEASE COMPLETE FOR EACH FAMILY MEMBER, PLACING AN X IN THE APPROPRIATE BOX:

	SELF	FATHER	MOTHER	GRANDPARENTS (FATHER)	GRANDPARENTS (MOTHER)	SIBLINGS
ALLERGIES						
BLOOD DISORDERS/ ANEMIA						
CANCER/TUMORS						
DEPRESSION/ MENTAL ILLNESS						
DIABETES						
DRUG ABUSE						
HEART DISEASE						
HEPATITIS						
HIGH BLOOD PRESSURE						
HIV						
KIDNEY OR BLADDER DISORDER						
SEIZURES						
STROKE						
TUBERCULOSIS						
OTHER						
AGE OF DEATH IF APPLICABLE						

MAJOR HOSPITALIZATIONS: WRITE IN ANY RECENT HOSPITALIZATIONS FOR SERIOUS INJURY OR ILLNESS BELOW.

YEAR OPERATION OR ILLNESS	NAME OF HOSPITAL CITY AND STATE
YEAR OPERATION OR ILLNESS	NAME OF HOSPITAL CITY AND STATE
YEAR OPERATION OR ILLNESS	NAME OF HOSPITAL CITY AND STATE
YEAR OPERATION OR ILLNESS	NAME OF HOSPITAL CITY AND STATE

PREVIOUS PREGNANCIES:

TOTAL PREGNANCIES	LIVING	MISCARRIAGES	ECTOPIC	INDUCED ABORTIONS

MEDICINES: MARK AN X IN THE BOX NEXT TO ANY OF THE FOLLOWING THAT YOU ARE NOW TAKING:

ASPIRIN IBUPROFEN ACETAMINOPHEN (TYLENOL) OTHER: _____
 ANTACIDS LAXATIVES COLD TABLETS VITAMINS: _____
 ORAL CONTRACEPTIVES DIET PILLS TRANQUILIZERS
 HERBS: _____ FIBER SUPPLEMENTS SLEEPING PILLS
 HAY FEVER TABLETS BLOOD PRESSURE PILLS BLOOD THINNING PILLS INSULIN, DIABETIC PILLS

DRUG ALLERGIES: PLEASE LIST.

HABITS: PLEASE CHECK ANY OF THE HABITS LISTED BELOW WHICH APPLY TO YOU NOW OR IN THE PAST.

COFFEE: <input type="checkbox"/> NO <input type="checkbox"/> YES CUPS PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____
TOBACCO: <input type="checkbox"/> NO <input type="checkbox"/> YES CIGARETTES PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____
ALCOHOL: <input type="checkbox"/> NO <input type="checkbox"/> YES USE PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____
MARIJUANA: <input type="checkbox"/> NO <input type="checkbox"/> YES USE PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____
CRACK/ COCAINE: <input type="checkbox"/> NO <input type="checkbox"/> YES USE PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____
HEROIN: <input type="checkbox"/> NO <input type="checkbox"/> YES USE PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____
OTHER: USE PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____
OTHER: USE PER DAY/WEEK	AGE STARTED: _____ AGE QUIT: _____

CHECK ALL THAT APPLY

GENERAL

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	POOR APPETITE
<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE APPETITE
<input type="checkbox"/>	<input type="checkbox"/>	INSOMNIA
<input type="checkbox"/>	<input type="checkbox"/>	FATIGUE
<input type="checkbox"/>	<input type="checkbox"/>	FEVERS
<input type="checkbox"/>	<input type="checkbox"/>	NIGHT SWEATS
<input type="checkbox"/>	<input type="checkbox"/>	SWEAT EASILY
<input type="checkbox"/>	<input type="checkbox"/>	CHILLS
<input type="checkbox"/>	<input type="checkbox"/>	LOCALIZED WEAKNESS
<input type="checkbox"/>	<input type="checkbox"/>	POOR COORDINATION
<input type="checkbox"/>	<input type="checkbox"/>	CHANGE IN APPETITE
<input type="checkbox"/>	<input type="checkbox"/>	STRONG THIRST
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

SKIN & HAIR

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	RASHES
<input type="checkbox"/>	<input type="checkbox"/>	HIVES
<input type="checkbox"/>	<input type="checkbox"/>	ITCHING
<input type="checkbox"/>	<input type="checkbox"/>	ECZEMA
<input type="checkbox"/>	<input type="checkbox"/>	PIMPLES
<input type="checkbox"/>	<input type="checkbox"/>	DRYNESS
<input type="checkbox"/>	<input type="checkbox"/>	TUMORS, LUMPS
<input type="checkbox"/>	<input type="checkbox"/>	BRUISES EASILY
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

HEAD & NECK

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	DIZZINESS
<input type="checkbox"/>	<input type="checkbox"/>	FAINTING
<input type="checkbox"/>	<input type="checkbox"/>	NECK STIFFNESS
<input type="checkbox"/>	<input type="checkbox"/>	ENLARGED LYMPH GLANDS
<input type="checkbox"/>	<input type="checkbox"/>	HEADACHES
<input type="checkbox"/>	<input type="checkbox"/>	CONCUSSIONS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

EARS

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	INFECTION
<input type="checkbox"/>	<input type="checkbox"/>	RINGING
<input type="checkbox"/>	<input type="checkbox"/>	DECREASED HEARING
<input type="checkbox"/>	<input type="checkbox"/>	PAIN
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

EYES

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	BLURRED VISION
<input type="checkbox"/>	<input type="checkbox"/>	VISUAL CHANGES
<input type="checkbox"/>	<input type="checkbox"/>	POOR NIGHT VISION
<input type="checkbox"/>	<input type="checkbox"/>	SPOTS
<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS
<input type="checkbox"/>	<input type="checkbox"/>	GLASSES / CONTACTS
<input type="checkbox"/>	<input type="checkbox"/>	EYE INFLAMMATION
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

NOSE, THROAT, MOUTH

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS
<input type="checkbox"/>	<input type="checkbox"/>	SINUS INFECTIONS
<input type="checkbox"/>	<input type="checkbox"/>	HAY FEVER OR ALLERGIES
<input type="checkbox"/>	<input type="checkbox"/>	RECURRING SORE THROATS
<input type="checkbox"/>	<input type="checkbox"/>	GRINDING TEETH

<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY SWALLOWING
<input type="checkbox"/>	<input type="checkbox"/>	ORAL ULCERS
<input type="checkbox"/>	<input type="checkbox"/>	CHANGES IN TASTE/SMELL
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

CARDIOVASCULAR

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD CLOTS
<input type="checkbox"/>	<input type="checkbox"/>	PALPITATIONS
<input type="checkbox"/>	<input type="checkbox"/>	FAINTING
<input type="checkbox"/>	<input type="checkbox"/>	PHLEBITIS
<input type="checkbox"/>	<input type="checkbox"/>	CHEST PAIN
<input type="checkbox"/>	<input type="checkbox"/>	IRREGULAR HEART BEAT
<input type="checkbox"/>	<input type="checkbox"/>	COLD HANDS / FEET
<input type="checkbox"/>	<input type="checkbox"/>	SWELLING OF HANDS / FEET
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

RESPIRATORY

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA
<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT COLDS
<input type="checkbox"/>	<input type="checkbox"/>	COPD
<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	COUGH
<input type="checkbox"/>	<input type="checkbox"/>	COUGHING BLOOD
<input type="checkbox"/>	<input type="checkbox"/>	PRODUCTION OF PHLEGM
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

GASTRO-INTESTINAL

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	NAUSEA
<input type="checkbox"/>	<input type="checkbox"/>	VOMITING
<input type="checkbox"/>	<input type="checkbox"/>	DIARRHEA
<input type="checkbox"/>	<input type="checkbox"/>	BELCHING
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD IN STOOLS/ BLACK STOOLS
<input type="checkbox"/>	<input type="checkbox"/>	BAD BREATH
<input type="checkbox"/>	<input type="checkbox"/>	RECTAL PAIN
<input type="checkbox"/>	<input type="checkbox"/>	HEMORRHOIDS
<input type="checkbox"/>	<input type="checkbox"/>	CONSTIPATION
<input type="checkbox"/>	<input type="checkbox"/>	PAIN OR CRAMPS
<input type="checkbox"/>	<input type="checkbox"/>	INDIGESTION
<input type="checkbox"/>	<input type="checkbox"/>	GALL BLADDER DISORDER
<input type="checkbox"/>	<input type="checkbox"/>	GAS
<input type="checkbox"/>	<input type="checkbox"/>	RECENT CHANGE IN WEIGHT
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

GENITO-URINARY

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY STONES
<input type="checkbox"/>	<input type="checkbox"/>	PAINFUL URINATION
<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT URINATION
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD IN URINE
<input type="checkbox"/>	<input type="checkbox"/>	URGENCY TO URINATE
<input type="checkbox"/>	<input type="checkbox"/>	UNABLE TO HOLD URINE
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

MALE

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	PAIN / ITCHING GENITALIA
<input type="checkbox"/>	<input type="checkbox"/>	GENITAL LESIONS / DISCHARGE
<input type="checkbox"/>	<input type="checkbox"/>	IMPOTENCE
<input type="checkbox"/>	<input type="checkbox"/>	WEAK URINARY STREAM
<input type="checkbox"/>	<input type="checkbox"/>	LUMPS IN TESTICLES
<input type="checkbox"/>	<input type="checkbox"/>	PROSTATE CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

FEMALE

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT URINARY TRACT INFECTIONS
<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT VAGINAL INFECTIONS
<input type="checkbox"/>	<input type="checkbox"/>	PAIN / ITCHING OF GENITALIA
<input type="checkbox"/>	<input type="checkbox"/>	GENITAL LESIONS/ DISCHARGE
<input type="checkbox"/>	<input type="checkbox"/>	PELVIC INFLAMMATORY DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL PAP SMEAR
<input type="checkbox"/>	<input type="checkbox"/>	IRREGULAR PERIODS
<input type="checkbox"/>	<input type="checkbox"/>	PAINFUL PERIODS
<input type="checkbox"/>	<input type="checkbox"/>	PREMENSTRUAL SYNDROME
<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL BLEEDING
<input type="checkbox"/>	<input type="checkbox"/>	MENOPAUSAL SYNDROME
<input type="checkbox"/>	<input type="checkbox"/>	BREAST LUMPS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER

NEUROLOGICAL

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	TREMORS
<input type="checkbox"/>	<input type="checkbox"/>	NUMBNESS/TINGLING OF LIMBS
<input type="checkbox"/>	<input type="checkbox"/>	CONCUSSION
<input type="checkbox"/>	<input type="checkbox"/>	PAIN
<input type="checkbox"/>	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	PERIPHERAL NEUROPATHY
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

PSYCHOLOGICAL

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION
<input type="checkbox"/>	<input type="checkbox"/>	ANXIETY / STRESS
<input type="checkbox"/>	<input type="checkbox"/>	IRRITABILITY
<input type="checkbox"/>	<input type="checkbox"/>	TREATED FOR EMOTIONAL OR PSYCHOLOGICAL PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIFFICULTY CONCENTRATING
<input type="checkbox"/>	<input type="checkbox"/>	ADDICTIVE PERSONALITY
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____

INFECTION SCREENING

<u>PAST</u>	<u>CURRENT</u>	<u>CONDITION</u>
<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS A B C
<input type="checkbox"/>	<input type="checkbox"/>	GONORRHEA
<input type="checkbox"/>	<input type="checkbox"/>	CHLAMYDIA
<input type="checkbox"/>	<input type="checkbox"/>	SYPHILIS
<input type="checkbox"/>	<input type="checkbox"/>	GENITAL WARTS
<input type="checkbox"/>	<input type="checkbox"/>	HERPES: ORAL
<input type="checkbox"/>	<input type="checkbox"/>	HERPES: GENITAL