

Beth Grubb, M.Ac. L.Ac. – New Patient Information Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name _____ Sex M ___ F ___ Date _____ Email _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Place of birth _____ Age ___ Height ___ Weight ___

Telephone: Home () _____ Work () _____ Cell () _____

___ Single ___ Married ___ Divorced ___ Widowed ___ Living with

Education _____ Occupation _____

Referred by: _____

Reason for visit today _____

Other problems _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your Sleep ___ Work ___ other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

| | self | mother | father | sibling | spouse | children |
|------------------------------------|------|--------|--------|---------|--------|----------|
| cancer or tumors | | | | | | |
| diabetes | | | | | | |
| blood or bleeding disorders/anemia | | | | | | |
| seizures | | | | | | |
| high blood pressure/heart disease | | | | | | |
| allergies | | | | | | |
| stroke | | | | | | |
| drug abuse | | | | | | |
| depression or mental illness | | | | | | |
| age of death | | | | | | |
| hepatitis | | | | | | |
| kidney disorders | | | | | | |
| thyroid disorders | | | | | | |
| musculo-skeletal disorder | | | | | | |
| blood transfusion (if before 1985) | | | | | | |

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (drinks per week) _____

Marijuana _____

Other recreational drugs _____

Vitamins & herbs _____

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise _____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) _____

MEDICINES:

Prescription drugs you are currently taking:

For what condition?

Over-the-counter medication you are currently taking:

For what condition?

MAJOR HOSPITALIZATIONS If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

| YEAR | OPERATION/ ILLNESS |
|------|--------------------|
| | |
| | |
| | |

Date of last physical examination: _____

Name & address of physician _____

Phone number of physician _____

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes/No

GYNECOLOGY

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yes/no when: _____ Length of cycle _____

Color of menstrual blood: pale/bright red/dark red/brown other _____

Texture of menstrual blood: thick/thin/watery/normal

Pain: yes/no when: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? yes/no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal/abnormal Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? yes/no Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other: _____

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

Nose, Throat & Mouth

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids

- Gall Bladder disorder

Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

Other
