

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)

- | | | |
|---|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Diet Pills |
| <input type="checkbox"/> Allergy Pills | <input type="checkbox"/> Diet Pills | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Blood Thinning Pills | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> Blood Pressure Pills | <input type="checkbox"/> Cold Medicine | <input type="checkbox"/> Prescription Pain Pills |
| <input type="checkbox"/> Cholesterol Pills | <input type="checkbox"/> Diuretic Pills | <input type="checkbox"/> Anticonvulsant Pills |
| <input type="checkbox"/> 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cups each day/week_____ | Age began__ | Age quit__ |
| Tea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cups each day/week_____ | Age began__ | Age quit__ |
| Caffeinated Soda | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cups each day/week_____ | Age began__ | Age quit__ |
| Tobacco | <input type="checkbox"/> Yes <input type="checkbox"/> No | # Cigarettes/day_____ | Age began__ | Age quit__ |
| Marijuana | <input type="checkbox"/> Yes <input type="checkbox"/> No | Use each day/week_____ | Age began__ | Age quit__ |
| Alcohol | <input type="checkbox"/> Yes <input type="checkbox"/> No | # Drinks each day/week_____ | Age began__ | Age quit__ |
| Cocaine/Crack | <input type="checkbox"/> Yes <input type="checkbox"/> No | Use each day/week_____ | Age began__ | Age quit__ |
| Heroin | <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____

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: _____

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 | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative |
| TB | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative Type: |
| Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative |
| Chlamydia | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative |
| Syphilis | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative |
| Genital warts | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative |
| Herpes | <input type="checkbox"/> | <input type="checkbox"/> positive <input type="checkbox"/> negative Type: |

MALE

past current

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

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? _____