



## Acuremedy - Acupuncture and Chinese Herbal Medicine In Take form

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Date:

Please fill out this questionnaire to the best of your ability. All of your answers will be held confidential. Please add details when relevant. Thank you. (How do you find us?  friends  website  others

Name (Last, First Name):	Home phone:	Work phone:
Address: #, Street	City	State/Zip
Date of Birth:	Age	Email Address:
Occupation:	Physician (name, phone #):	Height/Weight:
Emergency Contact (name): (phone #):		Relation to you:
Are you a member of Blue Cross? ( Y or N )		Referred by:

Have you been treated by acupuncture or Oriental Medicine before? ( Y or N )
Main problems(s) you would like us to help you with?
How long ago did this problem begin? Please be specific. Length of time: Severity:
To what extent does this problem interfere with your daily activities, such as work, sleep, & sex?
Secondary or other problems:
What other kinds of treatment have you tried?

Past medical history? (circle all applicable) Cancer   diabetes   Hepatitis   High Blood Pressure   Heart Disease   Rheumatic Fever  Thyroid Disease   Seizures   Venereal Disease   HIV   AIDs   TB   Hep A/B/C   Other (please specify):
Surgeries (what? Date?):
Significant trauma (what? Date?):
Significant illness (what? Date?):
Allergies (drugs, chemicals, foods):
Family Medical History: (circle all applicable) Diabetes   Cancer   High Blood Pressure   Heart Disease   Stroke   Seizures   Asthma  Allergies   Others
Medicines taken within the last two months (vitamins, drugs, herbs, etc.)
Occupational stress (chemical, physical, psychological, etc.)



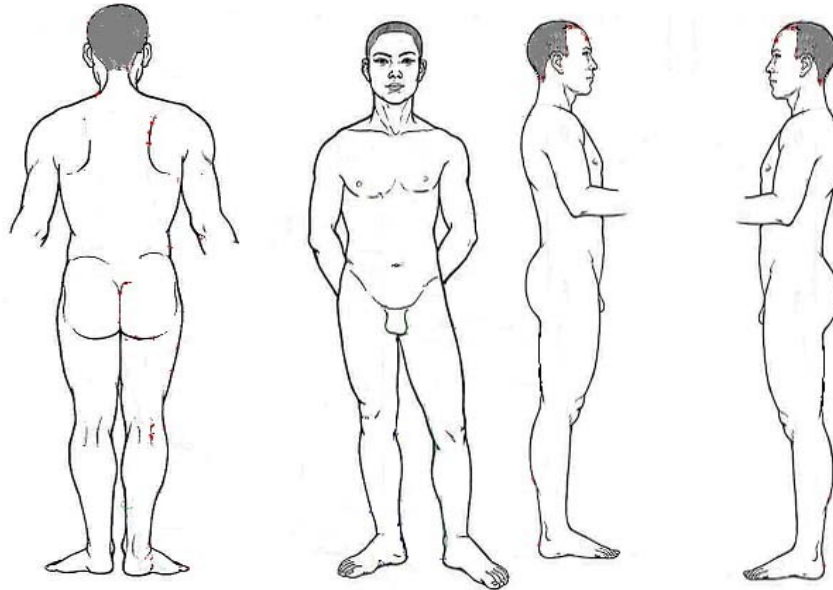
**Acuremedy - Acupuncture and Chinese Herbal Medicine**  
**In Take form**

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Date:

Do you have a regular exercise program? If yes, please describe.		
Have you been on restricted diet? If yes, what kind?		
Please describe your average daily diet: Morning: _____ Noon: _____ Evening: _____ _____		
Do you smoke? If yes, how much (# or packs)?		
How much caffeinated coffee, tea, or cola do you drink (# of cups daily)?		
Recreational Drugs? ( Y or N )		Alcohol use (# of drinks daily):
How much water do you drink per day? How much alcohol do you drink?		
Please describe any use of drugs for non-medical purposes.		

Indicate where the focal areas are:





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### Indicate in the box with an "X" if you suffer from:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Vision Problems 視力   | <input type="checkbox"/> Circulation 血循環                | <input type="checkbox"/> Muscular Tension 肌肉緊張             |
| <input type="checkbox"/> Hearing Problems 聽力  | <input type="checkbox"/> Heart 心臟                       | <input type="checkbox"/> Backache 腰背痛                      |
| <input type="checkbox"/> Nasal/Skin Allergies<br>鼻/皮膚過敏   | <input type="checkbox"/> Varicose Veins 靜脈曲張            | <input type="checkbox"/> Bone Pain 骨痛                      |
| <input type="checkbox"/> Bronchitis 支氣管炎  | <input type="checkbox"/> Memory 記憶力                     | <input type="checkbox"/> Insomnia 失眠                       |
| <input type="checkbox"/> Excessive Colds 易外感  | <input type="checkbox"/> Cholesterol 膽固醇                | <input type="checkbox"/> Diabetes 糖尿病                      |
| <input type="checkbox"/> Sinus 鼻竇炎  | <input type="checkbox"/> Nerves 精神緊張                    | <input type="checkbox"/> Anemia 貧血                         |
| <input type="checkbox"/> Bad Breath 口臭  | <input type="checkbox"/> Depression 抑鬱                  | <input type="checkbox"/> Asthma 哮喘                         |
| <input type="checkbox"/> Heartburn 胃脘灼熱感  | <input type="checkbox"/> Anxiety 憂慮                     | <input type="checkbox"/> Alcoholism/Smoke/Drugs 嗜<br>酒/煙/毒 |
| <input type="checkbox"/> Stomach Pains 胃脘痛  | <input type="checkbox"/> Fatigue 疲乏                     | <input type="checkbox"/> Prostate/Ovaries 前列腺/軟巢           |
| <input type="checkbox"/> Gas 噯氣   | <input type="checkbox"/> Migrains 偏頭痛                   | <input type="checkbox"/> Vaginal Infections 陰道炎            |
| <input type="checkbox"/> Appetite-Big-Small 食慾亢進/減<br>退   | <input type="checkbox"/> Headaches 頭痛                   | <input type="checkbox"/> Menstrual Problems 月經問題           |
| <input type="checkbox"/> Diarrhea 腹瀉  | <input type="checkbox"/> Kidneys 腎                      | <input type="checkbox"/> Pregnancy 妊娠                      |
| <input type="checkbox"/> Constipation 便秘  | <input type="checkbox"/> Excessive Urine 尿頻`多           | <input type="checkbox"/> Impotent 陽萎                       |
| <input type="checkbox"/> Inflamed Gums 齒?炎  | <input type="checkbox"/> Problems with urinating<br>尿問題 | <input type="checkbox"/> Frigidity 低性感                     |
| <input type="checkbox"/> Liver 肝  | <input type="checkbox"/> Rheumatism 風濕                  | <input type="checkbox"/> Menopause 更年期                     |
| <input type="checkbox"/> Gall Bladder 膽囊  | <input type="checkbox"/> Arthritis 關節炎                  | <input type="checkbox"/> Parasites 寄生蟲                     |
| <input type="checkbox"/> Appendicitis 闌尾  | <input type="checkbox"/> Legs & arms pain 下/上<br>肢痛     | <input type="checkbox"/> High/Low Blood Pressure<br>高/低血壓  |
| <input type="checkbox"/> Skin Problems: Eczema/Psoriasis/Acne/Dry/Greasy 皮膚病                          |   |  |
| <input type="checkbox"/> Hair Problems: Falls out excessively/Very Dry/Greasy/Dandruff/Saborrhea 毛髮問題 |   |  |