

Chinese Medicine for Health Patient Information Sheet

Name _____ Sex _____ Date of Birth _____ Age _____

Address _____ Town _____ State _____ Zip _____

Phone: Home _____ Cell _____ Business _____

e-mail _____

Occupation _____ Employer _____

Address _____

Spouse _____ Phone: Cell _____ Business _____

Emergency Contact: _____ Phone _____ Relationship _____

Primary Physician _____ Phone _____

Address _____ Date of Last Physical _____

Your weight _____ Your height _____ Do you smoke? _____ Do you drink? _____

*****HOW WERE YOU REFERRED TO US? _____**

Reason for visit and present symptoms: _____

Are you currently taking medication: () Yes () No Please list:

Please list any allergies to medication: _____

Other allergies: _____

Have you had before or currently have any of the following: (please circle)

Hypertension	Heart Disease	High Cholesterol	Stroke	Abnormal Bleeding
Seizures	Diabetes	Thyroid Problem	Cancer	Migraine Headaches
Anemia	Peptic Ulcer	Cirrhosis	Hepatitis	Tuberculosis
Head injury	HIV Positive	Schizophrenia	Depression	Other _____

History of Surgeries: _____

Do your relatives have any of the above? () Yes () No Please specify:

Have you ever had a blood transfusion? _____ When _____ Why _____

Activities: Please circle
Reading Writing Art Music Computer Sewing Hunting Flying Golfing
Tennis TV Swimming Jogging Walking Cards Dancing Tai Chi Aerobics
Biking Other

Have you seen other Alternative Therapists? _____ Type of Therapy _____

When _____ Result _____

Please sign: _____ Date: _____