SEA DRAGON
ACUPUNCTURE & HERB CLINIC

Confidential Patient Information

Name: _____ Date: _____

Address: _____ City:_____ Zip:_____

Home Telephone #: _____ Cell Telephone #:_____

Email Address:_____

Date of Birth: _____ Age: _____

Partner Status: ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone #: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student

Occupation: _____

Employer: _____

Primary Health Care Source

Physician's Name: _____ Telephone #: _____

Date of last visit or check up: _____

FOR FEMALES: Are you pregnant? ☐ Yes ☐ No ☐ Maybe
If yes or maybe, how far along? _____

FOR MINORS: List both parents' names and phone numbers below

Mother: _____ Phone:_____

Father: _____ Phone:_____

Financial Arrangements

How do you plan to handle your account? ☐ Card ☐ Check ☐ Other:_____

Will you need a receipt for insurance? ☐ Yes ☐ No

How did you hear about our Clinic: _____

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of my treatment.

X_____

Patient's Signature Date

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Initial Health Intake Form

Name: _____ Date: _____

Have you ever had acupuncture treatment? ☐Yes ☐No

When and for what reason?_____
Are you presently being treated for a medical condition? ☐Yes ☐No

If yes, please describe:_____

Please briefly describe any chronic pain:_____
What health issue do you want treated? Please describe as fully as possible

_____
What treatment have you been using for relief of this issue?

_____
Do you have other health concerns?

_____
Please describe the time you typically eat, and the types of foods you eat regularly:

Time: _____ Breakfast: _____
Time: _____ Morning snack: _____
Time: _____ Lunch: _____
Time: _____ Afternoon snack: _____
Time: _____ Dinner: _____
Time: _____ Evening snack: _____

Do you exercise regularly? ☐Yes ☐No If yes, what type of exercise? _____
Is there anything else you would like me to know about your health or health goals? ☐Yes ☐No
If yes, please describe: _____

HEALTH CONDITIONS - Indicate X if you have any of the following conditions and list any medication for it.

☐ Allergies/hayfever:_____	☐ Heart disease: _____	☐ Stroke:_____
☐ Anxiety:_____	☐ High blood pressure:_____	☐ Tuberculosis:_____
☐ Blood disorder_____		
☐ Cancer and/or tumors: _____	☐ Hospitalizations (major) or surgeries	☐ Other. Specify:
☐ Constipation:_____	☐ Insomnia:_____	☐ Other. Specify:
☐ Diabetes:_____	☐ Kidney or bladder disorder:_____	
☐ Diarrhea:_____	☐ Seizures:_____	☐ Other. Specify:
☐ Depression:_____		
☐ Drug abuse:_____		

MEDICINES – Mark an X in the box next to any of the following that you are now taking; please specify medication.

☐ Aspirin (Excedrin)	☐ Ibuprofen (Advil, Motrin)	☐ Acetaminophen (Tylenol)
☐ Antacids:_____	☐ Diet pills:_____	☐ Oral contraceptives:_____
☐ Other: _____	☐ Other:_____	☐ Other: _____

Vitamins (please list): _____

Supplements (please list): _____

Food or Drug Allergies: _____

HABITS: Please check any of the habits listed below which apply to you now or in the past.

Caffeine	☐Yes	☐No	___cups/day	Age started	Age quit
Tobacco	☐Yes	☐No	___# cigarettes per day	Age started	Age quit
Marijuana	☐Yes	☐No	___ use per day	Age started	Age quit
Alcohol	☐Yes	☐No	___ use per day	Age started	Age quit
Other _____			___ use per day	Age started	Age quit

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Initial Health Intake Form

Name: Date:

GENERAL

Past	Current	
☐	☐	Decreased Appetite
☐	☐	Excessive Appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night Sweats
☐	☐	Sweat Easily
☐	☐	Chills
☐	☐	Localized Weakness
☐	☐	Poor Coordination
☐	☐	Change in Appetite
☐	☐	Strong Thirst
☐	☐	Other

SKIN & HAIR

☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors, lumps

HEAD & NECK

☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck stiffness
☐	☐	Enlarged lymph glands
☐	☐	Headaches
☐	☐	Concussions*
☐	☐	Other

EARS

☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other

EYES

☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Spots
☐	☐	Cataracts
☐	☐	Glasses/contacts
☐	☐	Eye inflammation
☐	☐	Other

NOSE, THROAT & MOUTH

☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Hay fever or allergies
☐	☐	Recurring sore throats
☐	☐	Grinding teeth
☐	☐	Difficulty swallowing

CARDIOVASCULAR

Past	Current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Fainting
☐	☐	Phlebitis/Blood clots
☐	☐	Chest Pain
☐	☐	Irregular heart beat
☐	☐	Cold hands/feet
☐	☐	Swelling of hands/feet
☐	☐	Other

RESPIRATORY

☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	COPD/Chronic Bronchitis or Emphysema
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Other

GASTROINTESTINAL

☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/black stools
☐	☐	Bad breath
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gall bladder disorder
☐	☐	Gas
☐	☐	Other

GENITO-URINARY

☐	☐	Kidney stones
☐	☐	Pain on urination
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Urgency to urinate
☐	☐	Unable to hold urine
☐	☐	Other

MALE

☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Impotence
☐	☐	Weak urinary stream
☐	☐	Lumps in testicles
☐	☐	Other

FEMALE

Past	Current	
☐	☐	Frequent Urinary Tract Infection
☐	☐	Frequent vaginal infections
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions/discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal pap smear
☐	☐	Irregular periods
☐	☐	Painful menstrual periods
☐	☐	Abnormal pap smears
☐	☐	Menopausal syndrome
☐	☐	Breast lumps
☐	☐	Other

NEUROLOGICAL

☐	☐	Seizures*
☐	☐	Tremors
☐	☐	Numbness or tingling of limbs
☐	☐	Brain injury (TBI, stroke, etc.)
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other

PSYCHOLOGICAL

☐	☐	Depression
☐	☐	Anxiety/stress
☐	☐	Irritability
☐	☐	Treated for emotional/ psychological problems
☐	☐	Other

POSITIVE PRESENT/PAST INFECTIONS

☐	☐	HIV
☐	☐	TB
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Chlamydia
☐	☐	Syphilis
☐	☐	Genital warts
☐	☐	Herpes: oral/genital

* If you have a history of concussions and/or brain injury please ask to complete the Brain Health Intake form where you can detail the history.