WEI'S CHINESE MEDICAL CENTER

6250 Lantana Rd, Suite 25, Lake Worth, FL 33463

Today's Date: _____

Name Last_____First_____ **Date of Birth**_____ /_____ /_____ Age: ____
Gender F M **Marital Status:** M☐ S☐ D☐ W☐ Email _____

Address _____City _____State _____
Zip Code_____ **Telephone:** Cell Phone (_____) _____-_____
Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? We will not sell or give your email to any other agency. **Yes** _____ **No** _____

Height _____ Weight _____ HIV _____ HbsAg _____

How did you hear about our clinic or were you referred by someone? _____
Have you been treated by Acupuncture or Oriental medicine before? _____
Emergency Contact: Name_____ Phone: _____

Relationship _____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with:

_____

2. How long ago did this problem begin?

_____

3. Have you been given a diagnosis for this problem? If so, what?

_____

4. What kinds of treatment have you tried?

_____

Are you currently receiving treatment for your problem? _____If so, please describe:

_____

5. Does anything improve your problem?

_____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.) _____
Childhood health _____
Current Emotional Health _____
Current Predominant Emotion_____
Occupation _____Stress Level _____
Have you had any unusual stresses recently? _____
Do you have a regular exercise program? Yes ☐ No ☐ ___If so, please describe: _____
If applicable, please describe smoking or alcohol intake: _____

PAST MEDICAL HISTORY

Illnesses: _____

_____

Surgeries _____

_____

Significant Trauma (Auto accidents, falls, etc.)

_____

Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐ If so, please describe

_____

Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____

_____

Allergies

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side _____

Father's Side_____

Siblings _____

If any of the above is deceased, what was the cause? _____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

☐ Fevers	☐ Tremors	☐ Change in Appetite
☐ Chills	☐ Seizures	☐ Peculiar tastes or smells
☐ Fatigue	☐ Night Sweats	☐ Sudden energy drops?
What time of Day?		☐ Strong thirst for Hot or Cold drinks?
_____		
☐ Poor Sleep/ Insomnia	☐ Day Sweating	☐ Headaches
☐ Dream Disturbed Sleep	☐ Poor Balance	☐ Localized Weakness
☐ Depression	☐ Weight Loss	☐ Bleeding or Bruising
☐ Mania	☐ Weight Gain	☐ Joint Pain
☐ Emotional Changes	☐ Poor Appetite	☐ Others:_____

CARDIOVASCULAR

☐ High blood pressure	☐ Dizziness	☐ Swelling of Hands	☐ Blood Clots
☐ Irregular heartbeat	☐ Fainting	☐ Difficulty in Breathing	☐ Palpitations
☐ Low blood pressure	☐ Cold Sweats	☐ Cold Hands/Feet	☐ Others:_____
☐ Chest pain	☐ Swelling of Feet	☐ Phlebitis	

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Concussion
- ☐ Dizziness
- ☐ Headaches
- ☐ Migraines
- ☐ Easily Susceptible to Stress
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Fainting
- ☐ Disorientation
- ☐ Anxiety
- ☐ Poor Memory
- ☐ Easily Angered
- ☐ Depression
- ☐ Mania
- ☐ Others: _____

RESPIRATORY

- ☐ Cough
- ☐ Asthma
- ☐ Pain w/ Deep Breaths
- ☐ Bronchitis
- ☐ Difficulty in Breathing
- ☐ Shortness of Breath
- ☐ Easily Winded w/ Exertion when laying down
- ☐ Coughing Blood
- ☐ Production of phlegm What color? _____
- ☐ Others:_____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Ulcers
- ☐ Hernia
- ☐ Abdominal Pain/ Cramps
- ☐ Parasites
- ☐ Belching
- ☐ Bad Breath
- ☐ Hemorrhoids
- ☐ Digestive Disorders
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stools
- ☐ Others:_____

GENITO-URINARY

- ☐ Pain on Urination
- ☐ Urgent Urination
- ☐ Frequent Urination
- ☐ Unable to Hold Urine
- ☐ Decrease in Urine
- ☐ Blood in Urine
- ☐ Impotency/ Infertility
- ☐ Genital Sores
- ☐ Kidney sores
- ☐ Waking up to Urinate
  How often? _____
- ☐ Others:_____

MUSULOSKELETAL

- ☐ Muscular Weakness
- ☐ Muscle Cramps
- ☐ Injuries or Falls
- ☐ General Aches
- ☐ Arthritis
- ☐ Spasms
- ☐ Muscular Atrophy
- ☐ Joint Instability
- ☐ Recent Sprains
- ☐ Others:_____

FOR WOMEN ONLY

___Age at First Manses'
___Period between Manses'
___Duration of Manses'
Hysterectomy ☐ Yes ☐ No
☐ Heavy or ☐ Light
☐ Irregular Periods
☐ Painful Periods
STD (explain)_____

___ Number of Pregnancies
___ Number of Births
___ Miscarriages
___Abortions
☐ Difficult Births
☐ Breast Lumps
☐ Clots

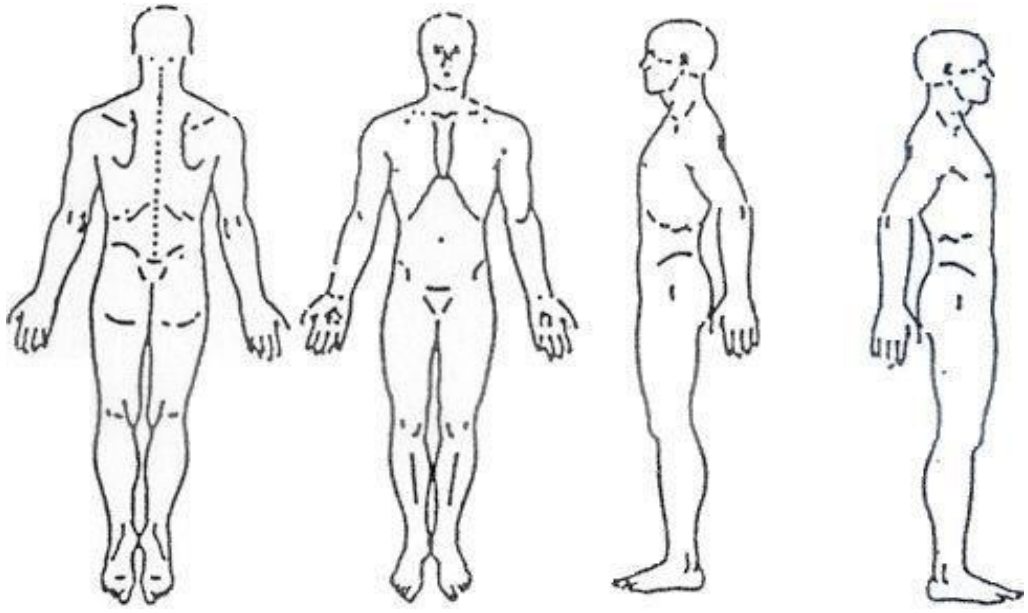
☐ Birth Control?
What type? _____
How long?_____
☐ Fertility Problems
☐ Vaginal Discharge
☐ Vaginal Sores
☐ Others:_____

Pregnancy □ Number of Pregnancies:_____□ Birth:_____□ Premature Birth:_____
□ Abortion:_____□ Infertility: _____□ Miscarriage:_____

FOR MEN ONLY

□ Prostate Infection □ Prostate cancer □ Enlarged Prostate □ Impotency □ Yeast Infection
□ STD_____ □ Other_____

Please circle on the diagram any areas of any type of pain or injury:



Please try to describe the type and quality of the pain _____

Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain the most intense pain

Are there any other internal organ or systemic dysfunctions that we should be aware of? _____

_____

Are there any other problems you would like to discuss? _____

Consent for Acupuncture

I understand that acupuncture uses fine needles and related techniques to help improve health and relieve symptoms. I understand that results vary and no guarantee has been made regarding outcomes. Possible side effects include mild soreness, bruising, fatigue, dizziness, or temporary discomfort; serious complications are rare. I have informed my practitioner of my medical conditions, medications, and pregnancy status if applicable. I voluntarily consent to receive acupuncture treatment and understand I may stop treatment at any time.

_____ _____

Patient's signature (Parent or Guardian if under 18) **Date**

Financial policy for services

I understand that I am financially responsible for all services rendered, including those not covered or reimbursed by insurance, and agree to pay all charges at the time of service

_____ _____

Patient's signature (Parent or Guardian if under 18) **Date**