



Welcome to East Coast Acupuncture & Herbs. Please fill out this form and bring it with you to your first appointment.
 To help us provide you with the best possible care, please fill out this form as completely as you can.
 All the information provided here will be held in strictest confidence. Feel free to ask if you have any questions.

Name _____
 Age _____ Date of Birth _____ Sex _____ Today's Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Mobile Phone _____
 Email _____ Occupation _____
 Emergency Contact _____ Telephone _____
 Physician _____ Telephone _____ May We Contact This Person? ____
 Have you been treated with acupuncture or Chinese herbs before? _____
 How did you hear about East Coast Acupuncture & Herbs? _____

PRIMARY REASON(S) FOR SEEKING TREATMENT

1) _____
 2) _____
 3) _____
 When did this/these problem(s) begin? _____
 What were the causes? _____
 What makes your symptom(s) better? _____ Worse? _____
 Please rate your current pain or discomfort on a scale of 1 to 10:
 Very Slight: 1 2 3 4 5 6 7 8 9 10 :Unbearable
 Have you received a diagnosis? _____ If so, what? _____
 What other treatments have you tried? _____

MEDICAL HISTORY (Include Dates) _____ Date of last physical exam _____
 Medications you are currently taking _____
 Supplements you are currently taking _____
 Allergies (food, drugs, chemicals, etc.) _____
 Major illnesses or significant traumas _____
 Surgeries _____

Check All That Apply:

- Anemia
- Hepatitis
- Lyme Disease
- Tuberculosis
- Asthma
- Heart Disease
- Pneumonia
- Other _____
- Cancer
- High Blood Pressure
- Seizures
- _____
- Diabetes
- HIV/AIDS
- Stroke

FAMILY MEDICAL HISTORY (Check All That Apply):

- Alcoholism / Addiction
- Cancer
- Heart Disease
- Psychological Disorders
- Arthritis
- Diabetes
- High / Low Blood Pressure
- Stroke

PERSONAL

Height _____ Weight _____ Weight Maximum _____ When? _____

Exercise (please describe) _____

Stress (occupational, emotional, etc.) _____

Do you smoke? _____ Did you used to smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____ How many drinks per week? _____

Do you drink caffeinated beverages? _____ What kind? _____ How many per day? _____

Please list any other drug use _____

PERSONAL SIGNS AND SYMPTOMS (Please check any that apply to you)

General

- | | | | |
|--|--|--|------------------------------------|
| <input type="radio"/> Bleed or Bruise Easily | <input type="radio"/> Fever | <input type="radio"/> Poor Balance | <input type="radio"/> Sweat Easily |
| <input type="radio"/> Chills | <input type="radio"/> Localized Weakness | <input type="radio"/> Poor Sleep | <input type="radio"/> Tremors |
| <input type="radio"/> Cravings | <input type="radio"/> Night Sweats | <input type="radio"/> Strong Thirst | <input type="radio"/> Weight Gain |
| <input type="radio"/> Fatigue | <input type="radio"/> Poor Appetite | <input type="radio"/> Sudden Energy Drop | <input type="radio"/> Weight Loss |

Musculoskeletal

- | | | | |
|---|--|---|--|
| <input type="radio"/> Back Pain | <input type="radio"/> Joint Pain / Stiffness | <input type="radio"/> Neck Pain / Tightness | <input type="radio"/> Swollen Hands / Feet |
| <input type="radio"/> Cold Hands / Feet | <input type="radio"/> Knee Pain | <input type="radio"/> Numbness | <input type="radio"/> Tingling |
| <input type="radio"/> Foot / Ankle Pain | <input type="radio"/> Muscle Atrophy | <input type="radio"/> Paralysis | <input type="radio"/> Tremors |
| <input type="radio"/> Hand / Wrist Pain | <input type="radio"/> Muscle Pain | <input type="radio"/> Sciatica | <input type="radio"/> Vertebral Disorder |
| <input type="radio"/> Hernia | <input type="radio"/> Muscle Twitches | <input type="radio"/> Shoulder Pain | |
| <input type="radio"/> Hip Pain | <input type="radio"/> Muscle Weakness | <input type="radio"/> Spinal Curvature | |

Head & Throat

- | | | | |
|---|---|---|---------------------------------------|
| <input type="radio"/> Blurry Vision | <input type="radio"/> Earaches | <input type="radio"/> Hearing Loss | <input type="radio"/> Ringing in Ears |
| <input type="radio"/> Cataracts | <input type="radio"/> Eye Pain / Strain | <input type="radio"/> Jaw Clicks / TMJ | <input type="radio"/> Sinus Problems |
| <input type="radio"/> Concussions | <input type="radio"/> Facial Pain | <input type="radio"/> Migraines | <input type="radio"/> Spots in Vision |
| <input type="radio"/> Difficulty Swallowing | <input type="radio"/> Frequent Sore Throats | <input type="radio"/> Mouth / Lip Sores | <input type="radio"/> Tearing |
| <input type="radio"/> Dizziness | <input type="radio"/> Headaches | <input type="radio"/> Night Blindness | <input type="radio"/> Teeth Grinding |
| <input type="radio"/> Dry Eyes | <input type="radio"/> Head Injury | <input type="radio"/> Nose Bleeds | <input type="radio"/> Tooth Pain |

Skin & Hair

- | | | | |
|--|---------------------------------|---------------------------------|------------------------------------|
| <input type="radio"/> Acne | <input type="radio"/> Dry Skin | <input type="radio"/> Itching | <input type="radio"/> Recent Moles |
| <input type="radio"/> Change in Hair Texture | <input type="radio"/> Eczema | <input type="radio"/> Psoriasis | <input type="radio"/> Ulcerations |
| <input type="radio"/> Change in Skin Texture | <input type="radio"/> Hair Loss | <input type="radio"/> Purpura | |
| <input type="radio"/> Dandruff | <input type="radio"/> Hives | <input type="radio"/> Rashes | |

Respiratory

- | | | | |
|----------------------------------|--|---|--|
| <input type="radio"/> Allergies | <input type="radio"/> Chest Pain | <input type="radio"/> Difficulty Breathing | <input type="radio"/> Persistent Cough |
| <input type="radio"/> Asthma | <input type="radio"/> Coughing Blood | <input type="radio"/> Emphysema | <input type="radio"/> Pleurisy |
| <input type="radio"/> Bronchitis | <input type="radio"/> Coughing Up Phlegm | <input type="radio"/> Frequent Common Colds | <input type="radio"/> Wheezing |

Cardiovascular

- | | | | |
|-----------------------------------|---|--|---------------------------------------|
| <input type="radio"/> Blood Clots | <input type="radio"/> Heart Murmurs | <input type="radio"/> Low Blood Pressure | <input type="radio"/> Rapid Heartbeat |
| <input type="radio"/> Chest Pain | <input type="radio"/> High Blood Pressure | <input type="radio"/> Palpitations | <input type="radio"/> Varicose Veins |
| <input type="radio"/> Fainting | <input type="radio"/> Irregular Heartbeat | <input type="radio"/> Phlebitis | |

Gastrointestinal

- | | | | |
|---|--|---------------------------------------|---|
| <input type="radio"/> Abdominal Pain / Cramps | <input type="radio"/> Crohn's Disease | <input type="radio"/> Hemorrhoids | <input type="radio"/> Rectal Pain |
| <input type="radio"/> Acid Reflux | <input type="radio"/> Constipation | <input type="radio"/> IBS | <input type="radio"/> Ulcers |
| <input type="radio"/> Bad Breath | <input type="radio"/> Diarrhea | <input type="radio"/> Indigestion | <input type="radio"/> Undigested Food in Stools |
| <input type="radio"/> Belching | <input type="radio"/> Gallbladder Problems | <input type="radio"/> Mucus in Stools | <input type="radio"/> Vomiting |
| <input type="radio"/> Black Stools | <input type="radio"/> Gas / Bloating | <input type="radio"/> Nausea | |
| <input type="radio"/> Blood in Stools | <input type="radio"/> Heartburn | <input type="radio"/> Parasites | |

Neuro-Psychological

- | | | | |
|---|--|---------------------------------------|-------------------------------|
| <input type="radio"/> ADD / ADHD | <input type="radio"/> Concussion | <input type="radio"/> Loss of Balance | <input type="radio"/> Stress |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Memory Loss | <input type="radio"/> Vertigo |
| <input type="radio"/> Bad Temper / Irritability | <input type="radio"/> Dizziness | <input type="radio"/> Mood Swings | |
| <input type="radio"/> Bipolar | <input type="radio"/> Lack of Coordination | <input type="radio"/> Seizures | |

Genito-Urinary

- | | | | |
|--|---|---|---|
| <input type="radio"/> Blood in Urine | <input type="radio"/> Frequent Urination at Night | <input type="radio"/> Inability to Hold Urine | <input type="radio"/> Pause of Urine Flow |
| <input type="radio"/> Burning Urination | <input type="radio"/> Genital Itching | <input type="radio"/> Kidney Stones | <input type="radio"/> Urinary Tract Infection |
| <input type="radio"/> Dribbling | <input type="radio"/> Genital Pain | <input type="radio"/> Painful Urination | <input type="radio"/> Urinary Urgency |
| <input type="radio"/> Frequent Urination | | | |

FEMALE

- | | | |
|---|--|--|
| <input type="radio"/> Breast Lumps | <input type="radio"/> Irregular Menstruation | <input type="radio"/> Polycystic Ovarian Syndrome |
| <input type="radio"/> Breast Tenderness | <input type="radio"/> Menopausal Symptoms | <input type="radio"/> Sexually Transmitted Disease |
| <input type="radio"/> Clotting During Menstruation | <input type="radio"/> Nipple Discharge | <input type="radio"/> Spotting |
| <input type="radio"/> Difficult / Painful Intercourse | <input type="radio"/> Ovarian Cysts | <input type="radio"/> Uterine Fibroids |
| <input type="radio"/> Endometriosis | <input type="radio"/> Painful Menstruation | <input type="radio"/> Vaginal Discharge |
| <input type="radio"/> Frequent Vaginal Infections | <input type="radio"/> Pelvic Infection | <input type="radio"/> Vaginal Dryness |
| <input type="radio"/> Infertility | <input type="radio"/> PMS | |

Is there any possibility that you may be pregnant? _____ Do you practice birth control? ____ What form? _____

Age at first menses _____ Date of last menses _____ Length of menstrual cycle _____ Duration of period _____

Number of pregnancies _____ Number of births _____ Number of miscarriages _____ Number of abortions _____

MALE

- | | | |
|--|---|--|
| <input type="radio"/> Erectile Dysfunction | <input type="radio"/> Frequent Seminal Emissions | <input type="radio"/> Premature Ejaculation |
| <input type="radio"/> Fertility Problems | <input type="radio"/> Painful / Swollen Testicles | <input type="radio"/> Prostate Problems |
| <input type="radio"/> Frequent Nocturnal Emissions | <input type="radio"/> Penile Discharge | <input type="radio"/> Sexually Transmitted Disease |

OFFICE POLICIES - PLEASE READ AND SIGN BELOW

- 1) If you wish to change an appointment, please give at least 24 hours advance notice. East Coast Acupuncture & Herbs will charge the full treatment price for any missed appointments or late cancellations.
- 2) All herb sales are final. East Coast Acupuncture & Herbs is not able to offer refunds on any herbs or herbal products.
- 3) Herbal prescriptions are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.

I understand the above information and guarantee this form was completed to the best of my knowledge:

Signature _____ Date _____