3547 Camino Del Rio South, Suite C
San Diego, CA 92108

Patient Information

Date: ____/____/_____

Name:_____ Date of Birth: ____/____/____ Age: _____

Address:_____City_____,State____,Zip Code:_____

Home Phone: (____)_____Work Phone: (____)_____

Cell Phone: (____)_____Carrier (AT&T, Verizon, Sprint, Etc.):_____
(We will text you to confirm your future appointments)

E-mail Address: _____

Would you like to be added to our E-mail Newsletter? Yes___ No___

Place of Birth: _____Guardian (if under 18): _____

Emergency Contact:_____Relation to you:_____ Phone:(____)_____

Marital Status: _____ Language Preference: _____

Gender: M F Height: ____'____" Weight: _____lbs.

Social Security #: ____-____-_____ Driver's License #: _____

Occupation: _____Employer_____

How did you hear about our center? (Please specify)

Family/Friend:_____Internet/Social Media:_____

Doctor's Referral:_____ Event:_____Other:_____

Have you had acupuncture before? Yes:____No:____

If yes, how was your experience? Please explain:_____

_____

_____

_____

Please list your symptoms/complaints you want addressed in <u>order of importance</u>:

Complaint #1: _____
What percentage of the time do you experience/feel this symptom? _____%
What Makes This Symptom Worse? _____
_____
What Makes This Symptom Better?_____
_____

Please rate your pain on a scale from 1 to 10 (10 being the worst): _____

Complaint #2: _____
What percentage of the time do you experience/feel this symptom? _____%
What Makes This Symptom Worse? _____
_____
What Makes This Symptom Better?_____
_____

Please rate your pain on a scale from 1 to 10 (10 being the worst): _____

Complaint #3: _____
What percentage of the time do you experience/feel this symptom? _____%
What Makes This Symptom Worse? _____
_____
What Makes This Symptom Better?_____
_____

Please rate your pain on a scale from 1 to 10 (10 being the worst): _____

Complaint #4: _____
What percentage of the time do you experience/feel this symptom? _____%
What Makes This Symptom Worse? _____
_____
What Makes This Symptom Better?_____
_____

Please rate your pain on a scale from 1 to 10 (10 being the worst): _____

Complaint #5: _____

What percentage of the time do you experience/feel this symptom? _____%
What Makes This Symptom Worse? _____
_____
What Makes This Symptom Better?_____
_____

Please rate your pain on a scale from 1 to 10 (10 being the worst): _____

How do these conditions affect your daily activities?: _____
_____
_____
_____

PAST MEDICAL HISTORY:

Childhood Illnesses/what age?_____
_____If no, please check here:_____(Denied)

Childhood Injuries/what age?_____
_____If no, please check here:_____(Denied)

Allergies:_____
_____If no, please check here:_____(Denied)

Surgeries: what age?_____
_____If no, please check here:_____(Denied)

Hospitalizations/what age?_____
_____If no, please check here:_____(Denied)

Adult Illnesses/what age?_____
_____If no, please check here:_____(Denied)

FAMILY HISTORY:

List any health problems in your immediate family: Mother:_____Father:_____

Brother:_____Sister:_____ If no, please check here: _____(Denied)

REVIEW OF SYSTEMS:

Please list any problems that you now have with the following body systems:

Ears/Nose/Throat:_____ No problems: _____ (Denied)
Eyes:_____ No problems: _____ (Denied)
Lungs:_____ No problems: _____ (Denied)
Liver:_____ No problems: _____ (Denied)
GI Tract (Stomach, Intestines, Bowels, Etc.): _____ No problems: _____ (Denied)
Kidney/Bladder: _____ No problems: _____ (Denied)
[Women Only] Reproductive System:_____ No problems: _____ (Denied)
Skin:_____ No problems: _____ (Denied)
Neurological:_____ No problems: _____ (Denied)
Heart/Circulation: _____ No problems: _____ (Denied)
Psychological: :_____ No problems: _____ (Denied)
HIV/STD: _____ No problems: _____ (Denied)
Other: :_____ No problems: _____ (Denied)
Do you have a pacemaker: _____NO ____YES
Do you have any other electrical device implants: _____NO ____YES
Explain_____
[Women Only] Is there any possibility you are pregnant? _____NO ____YES
Last menstrual cycle_____

Medication(s) you are currently taking and for what condition(s):_____

_____

_____

_____(If more, please check here and list on the back of this page): ____