



**Acupuncture For Life**  
*Stroke, Pain, Stress, Quit Smoking, and more*

**Caroline Chen, L.Ac.**  
 (832) 660-5281  
 www.acuforlife.com

**PATIENT HISTORY**

1. What is your chief complaint? \_\_\_\_\_
2. How did this condition develop? \_\_\_\_\_
3. How long has this condition persisted? \_\_\_\_\_
4. Have you ever received any treatment for this condition?  Yes  No  
 If yes, where? \_\_\_\_\_  
 When? \_\_\_\_\_  
 By whom? \_\_\_\_\_  
 What was the diagnosis? \_\_\_\_\_  
 What kind(s) of treatment(s)? \_\_\_\_\_  
 What were the results of treatment? \_\_\_\_\_
5. Please list substances that you are allergic to \_\_\_\_\_  
 \_\_\_\_\_
6. (Female only) Are you pregnant or do you suspect that you may be pregnant? \_\_\_\_\_
7. List medications you are currently taking.  

Medications	Strength	How many per day	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
8. Have you tried acupuncture or Chinese medicine before?  Yes  No
9. List any major surgeries you have had.  

Date	Problem
_____	_____
_____	_____
_____	_____
_____	_____
10. Significant illness: (please check)

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Aids	<input type="checkbox"/> Seizures
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other _____	
11. Significant Trauma (auto accident, falls, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_