



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

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

Acupuncture For Life

Caroline F. Chen
Licensed Acupuncturist
(832) 660-5281

Diplomate of Acupuncture & Chinese Herbal Medicine (NCCAOM)

(Please Print)

Date _____ Home Phone _____

PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthday _____

Driver License No. _____ Social Security No. _____

Single Married Widowed Separated Divorced

Spouse's Name _____ Phone _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

In case of emergency, whom should we notify? _____

Relationship _____ Phone _____

Address _____

Primary Physician _____ Phone _____

Address _____

Whom may we thank for referring you? _____ Phone _____



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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.) _____



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HEALTH HISTORY
(confidential)

Name _____ Today's Date _____

| Please check (✓) symptoms you currently have or have had in the past year. | | | |
|---|---|--|--|
| <p>General</p> <input type="checkbox"/> Chills <input type="checkbox"/> Dizziness <input type="checkbox"/> Fatigue <input type="checkbox"/> Fevers <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Insomnia <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss | <p>Respiratory</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Coughing blood <input type="checkbox"/> Night sweats <input type="checkbox"/> Persistent cough <input type="checkbox"/> Phlegm production <input type="checkbox"/> Recurrent bronchitis <input type="checkbox"/> Shortness of breath | <p>Genitourinary</p> <input type="checkbox"/> Abnormal urine color <input type="checkbox"/> Blood or pus in urine <input type="checkbox"/> Burning urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Kidney stone <input type="checkbox"/> Poor bladder control <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Vertigo / drowsiness |
| <p>Eye, Ear, Nose, Mouth, Throat</p> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Cataracts <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Eye pain/strain <input type="checkbox"/> Glasses <input type="checkbox"/> Hay fever <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Olfactory problems <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Red / Inflamed eye <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Sores on lips / tongue <input type="checkbox"/> Taste change <input type="checkbox"/> Teeth problems <input type="checkbox"/> Vision - halos | <p>Cardiovascular</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins | <p>Musculoskeletal Pain, weakness, and/or numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Back <input type="checkbox"/> Feet <input type="checkbox"/> Hands <input type="checkbox"/> Hips <input type="checkbox"/> Joints <input type="checkbox"/> Legs <input type="checkbox"/> Muscle <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders | <p>Men Only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Genital pain <input type="checkbox"/> Impotence <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge |
| | <p>Gastrointestinal</p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Black stools <input type="checkbox"/> Bloating <input type="checkbox"/> Blood in stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn / Reflux <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Poor appetite <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood | <p>Skin</p> <input type="checkbox"/> Blood not clotting <input type="checkbox"/> Bruise easily <input type="checkbox"/> Discoloration <input type="checkbox"/> Lumps in groins <input type="checkbox"/> Lumps underarm <input type="checkbox"/> Skin problem | <p>Women Only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Contraceptives <input type="checkbox"/> Irregular periods <input type="checkbox"/> Menopausal <input type="checkbox"/> Painful periods <input type="checkbox"/> Sores on genitalia <input type="checkbox"/> Vaginal discharge |
| | | | <p>Number of: ___ Pregnancies ___ Miscarriages ___ Children ___ Abortions</p> <p>Date of: Last menstrual period: _____</p> <p>Last Pap Smear: _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> |



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Notice To The Acupuncturist

(Pursuant to the requirement of Section 6.11, subsections (b) through (d) V.A.C.S. article 4495b, governing the practice of acupuncture.)

I (patient's name) _____ am notifying the acupuncturist, Caroline F. Chen, L.Ac.:

Yes No I have been evaluated by a physician or dentist for the condition being treated within the 12 months prior to the acupuncture treatment. I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist.

_____ (Initials of patient) Date: _____

- OR -

Yes No I have received a referral from my chiropractor within the last 30 days prior to the acupuncture treatment.

After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

Signature: _____ Date: _____