

Healing Art Acupuncture & Massage

Patient Information Chart

NEUROPSYCHOLOGICAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Considered suicide | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Physically abused | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Emotionally abused | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Sexually abused | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mania | <input type="checkbox"/> Lack of coordination |
| <input type="checkbox"/> Cry often | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Unfocused/confused thoughts |
| <input type="checkbox"/> Hospitalized for emotional issues | In therapy Yes NO | <input type="checkbox"/> Cancer (type) _____ |
- Do you feel you get adequate affection in your life?
- _____
- _____

Other: (accidents etc) _____

REPRODUCTIVE & GYNECOLOGICAL (Women only)

- | | | |
|---|--|---|
| _____ # of Pregnancies | _____ # of Births | _____ # of Miscarriages |
| <input type="checkbox"/> Long periods (7 days or more) | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal discharge (color & odor) |
| <input type="checkbox"/> Short periods (3 days or less) | <input type="checkbox"/> Clotting | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> PMS- breast distension | <input type="checkbox"/> Menopausal symptoms |
| <input type="checkbox"/> Painful ovulation | <input type="checkbox"/> PMS- emotional symptoms | <input type="checkbox"/> Birth control (what type?) _____ |
- Other: _____

**Please let your practitioner know if there is any chance you may be pregnant today.
Some acupuncture points and herbs are contraindicated during pregnancy.**

I, (patients's name), _____, am notifying the Acupuncturist, Tzong Jiunn Wu of the following:

I have been evaluated by a physician or dentist for the condition being treated within six (6) months before this acupuncture treatment was performed YES NO

I recognize that I *should* be evaluated by a physician for the condition being treated by the acupuncturist _____
Patient's initials

I have received a referral from my chiropractor within the last 30 days for acupuncture YES NO NA

After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if 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* whether to follow this advice.

→ _____
Signature of Patient

Date

Signature of Acupuncturist

Date

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PATIENT MEDICAL HISTORY

The following is a list of symptoms, which you may or may not have experienced:

No Mark= never experience > = Sometimes experience + = Frequently experience

CARDIOVASCULAR		RESPIRATORY		MALES ONLY	
Shortness of breath		Cough		Prostate Problems	
High Blood Pressure		Coughed up blood		Pain in Testicles	
Irregular Heart Beat		Sore Throats			
Heart Palpitations		Nasal Problems		FEMALES ONLY	
Dizziness		Nose Bleed			
Chest Pain or Pressure		Asthma or Wheezing		Pre-Menstrual Pain	
Leg Cramps		Pneumonia		Menstrual Pain	
		Hay fever		Irregular Menstrual Cycle	
		Bronchitis			
GASTROINTESTINAL		COPD		MISCELLANEOUS	
		TB			
Indigestion				Jaundice (Yellowish Skin)	
Abdominal Pain or cramps		GENITOURINARY		Hepatitis C	
Gall Stones				Hepatitis B	
Constipation		Kidney Stones		HIV	
Diarrhea		Frequent Urination		Memory Loss	
Blood in Bowel Movement		Painful Urination		Headaches	
Black Bowel Movement		Bloody Discharge		How frequent?	
Excess Appetite		Venereal Disease		Insomnia	
Decrease Appetite		Pain in Genital area		Fever	
Excess Thirst		Poor Bladder Control		Chills	
Loss of Thirst		Decrease Sex Drive		Night Sweats	
Nausea and Vomiting				Intolerance-Weather change	
Colitis or Diverticulitis		MUSCULO-SKELETAL			
Belching or Burping				OTHER	
Heartburn		Back Pain			
Difficulty Swallowing		Arthritis		Allergic to Alcohol	
		Muscle Pain or Cramps		Allergic to Medicines	
EYES and EARS		Painful Joints		Cancer type	
Macular Degeneration		SKIN		Please list:	
Blurred Vision		Ulcerations			
Sudden Hearing loss		Where?			
Hearing Loss due to accident		Psoriasis			
Jaundice (yellow eyes)		Xerosis			
Ringling in the ears		Hives			