

CONFIDENTIAL CASE HISTORY

NAME: LAST FIRST MIDDLE			SEX	AGE	BIRTH DATE	TODAY'S DATE
STREET ADDRESS			MARRIAGE STATUS M S W D		WEIGHT	FEMALES — ARE YOU PREGNANT? _____ LMP _____
CITY	STATE	ZIP	SOCIAL SECURITY NO			OCCUPATION
HOME PHONE		BUSINESS PHONE		REFERRED BY		DRIVER'S LICENSE NO
NEXT OF KIN		RELATIONSHIP		AUTO ACCIDENT <input type="checkbox"/>	WORKER'S COMP <input type="checkbox"/>	OTHER <input type="checkbox"/>
STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)			INSURANCE COMPANY			NO COVERAGE <input type="checkbox"/>
CITY	STATE	ZIP	PHONE	NAME OF INSURED PERSON		IDENTIFICATION NO.
			EMPLOYER'S NAME			PHONE
			STREET ADDRESS			
			CITY	STATE	ZIP	

Why are you coming to our office? _____

This is a new illness This is an old illness
 It was treated before It has not been treated
 If treated before, what was done? _____

CHECK IF YOU OR A BLOOD RELATIVE HAVE HAD OR HAVE ANY OF THESE:

	YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE
anemia	<input type="checkbox"/>	<input type="checkbox"/>	kidney or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>
asthma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	mental disorder	<input type="checkbox"/>	<input type="checkbox"/>
bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism or arthritis	<input type="checkbox"/>	<input type="checkbox"/>
cancer or tumor	<input type="checkbox"/>	<input type="checkbox"/>	stroke	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	ulcer or stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	numbness	<input type="checkbox"/>	<input type="checkbox"/>
gout	<input type="checkbox"/>	<input type="checkbox"/>	sciatica	<input type="checkbox"/>	<input type="checkbox"/>
heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	headaches	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
scoliosis	<input type="checkbox"/>	<input type="checkbox"/>			

When? _____ By whom? _____

Have you had Acupuncture before? Yes No

When? _____ By whom? _____

HAVE YOU HAD PROBLEMS WITH THESE? CHECK YES OR NO

	YES	NO		YES	NO
lumps	<input type="checkbox"/>	<input type="checkbox"/>	hearing	<input type="checkbox"/>	<input type="checkbox"/>
moles	<input type="checkbox"/>	<input type="checkbox"/>	seeing	<input type="checkbox"/>	<input type="checkbox"/>
swelling	<input type="checkbox"/>	<input type="checkbox"/>	smelling	<input type="checkbox"/>	<input type="checkbox"/>
stiff joints	<input type="checkbox"/>	<input type="checkbox"/>	racing heart	<input type="checkbox"/>	<input type="checkbox"/>
dizziness	<input type="checkbox"/>	<input type="checkbox"/>	digestion	<input type="checkbox"/>	<input type="checkbox"/>
balance	<input type="checkbox"/>	<input type="checkbox"/>	weight	<input type="checkbox"/>	<input type="checkbox"/>
appetite	<input type="checkbox"/>	<input type="checkbox"/>	constipation	<input type="checkbox"/>	<input type="checkbox"/>
sleeping	<input type="checkbox"/>	<input type="checkbox"/>	mood or feelings	<input type="checkbox"/>	<input type="checkbox"/>
breathing	<input type="checkbox"/>	<input type="checkbox"/>	(women only)		
pains, aches	<input type="checkbox"/>	<input type="checkbox"/>	menstruation	<input type="checkbox"/>	<input type="checkbox"/>

Last medical examination: _____

Who is or was your regular doctor? _____

City & State _____

Are you taking any medication? _____

Specify: _____

How are your dietary/nutritional habits? _____

Do you exercise regularly? _____

Explain: _____

Have you ever had surgery, or been hospitalized? _____

(Do not count normal births.)

Yes No If yes, what year? _____

Where? _____

What was wrong? _____

PATIENT SIGNATURE _____