YU'S ACUPUNCTURE & HERB CENTER

New Patient Information Questionnaire

Patient Name _____ Sex: __M, __F
First MI Last

Date of Birth _____/_____/_____ Height _____ Weight _____

Occupation: _____ Marital Status: ____Single, ____ Married, ____Other

Phone (Day) (_____)_____-_____ Phone (Evening) (_____)_____-_____

Phone (Cell Opt.) (_____)_____-_____ E-mail (Opt.) _____

Home Address: _____

City _____ State _____ Zip _____

Family Physician _____ Phone (_____)_____-_____

Referred by _____ Phone (_____)_____-_____

Emergency Information *(Please indicate who to notify in case of emergency)*

Name _____ Phone (H) (_____)_____-_____

Relationship _____ Phone (W/ C) (_____)_____-_____

Insurance Information

Insurance _____ 2nd Insurance_____

Policy Number _____ Policy Number _____

Phone (_____)_____-_____ Phone (_____)_____-_____

Subscriber's Name _____ Subscriber's Name _____

Date of Birth ____/____/_____, Sex: ___M, ___F Date of Birth ____/____/_____, Sex: ___M, ___F

Subscriber's Employer or School _____

Patient's Relationship to Subscriber: _____Self, _____Spouse, _____Child, _____Other

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with: _____, and assign directly to Yu's Acupuncture & Herb Center all insurance benefits, if any, otherwise payable for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____

YU'S ACUPUNCTURE & HERB CENTER

Confidential Patient Health History

Patient's Name_____ **Date** _____

Chief Complaint(s): *Please indicate how long you've had the condition(s).*

Other Complaint(s): *Please indicate how long you've had the condition(s).*

What kinds of treatments have you received?

Past Medical History:

List any Hospitalizations & Surgeries **Date** **Place**

_____
_____
_____
_____
_____
_____
_____

List medications being taken (include dose)

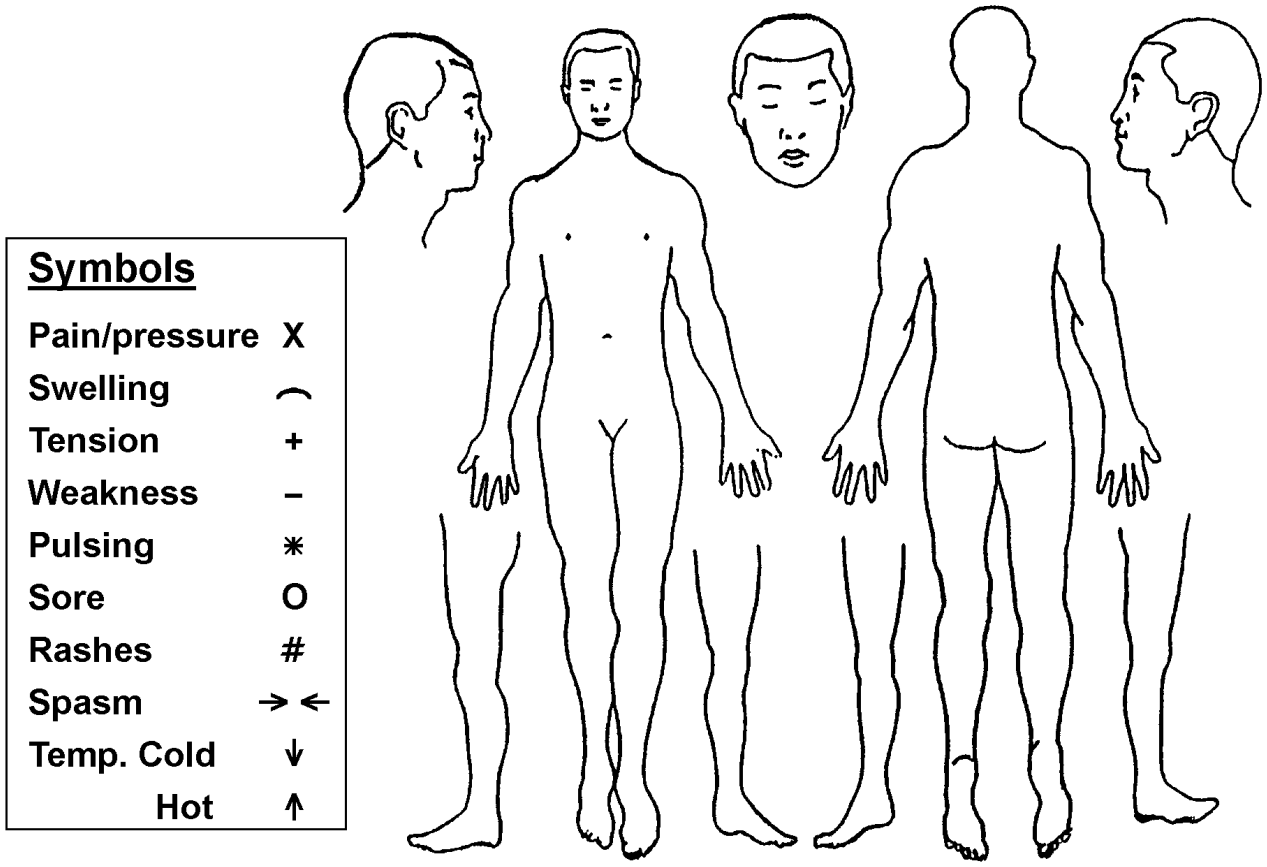
_____
_____
_____
_____
_____
_____
_____

YU'S ACUPUNCTURE & HERB CENTER

Nutritional Supplements

_____
_____
_____
_____
_____
_____
_____

Indicate painful or distressed areas:



Please check if you have had (in the past three months):

General

[] Anemia
[] Fatigue
[] Fever
[] Weight Loss
[] Sweats
[] Chills
[] Drug Addiction
[] Poor Appetite
[] Localized Weakness
[] Bleed or Bruise Easily
[] Peculiar Tastes or Smells
[] Strong Thirst (hot or cold drinks)
[] Sudden Energy Drop
[] Poor Sleep Habits
[] Tremors
[] Poor Balance
[] Cravings
[] Weight Gain
[] Alcoholism
[] Tetanus Shot
[] Frequent cold/flu

Skin and Hair

[] Rashes
[] Itching
[] Dandruff
[] Change in hair/skin texture
[] Ulcerations
[] Eczema
[] Open sore
[] Acne
[] Corns
[] Warts
[] Psoriasis
[] Shingles (herpes zoster)
[] Recent moles
[] Loss of Hair
[] Hives
[] Nail Problems
[] Dry skin

Head, Eyes, Ears, Nose and Throat

[] Dizziness/Vertigo
[] Poor Vision
[] Cataracts
[] Ringing in ears
[] Sinus Problems
[] Grinding Teeth
[] Nasal Congestion
[] Headaches
[] Concussions
[] Eye Strain
[] Night Blindness
[] Blurry Vision
[] Poor Hearing
[] Nose Bleeds
[] Hoarseness
[] Migraines
[] Eye Pain
[] Color Blindness
[] Earaches
[] Spots in front of eyes
[] Recurrent Sore Throats
[] Facial Pain

Cardiovascular

[] High Blood Pressure
[] Low Blood Pressure
[] Chest Pain
[] Varicose Veins
[] Swelling of Hands/Feet
[] Fainting
[] Myocarditis
[] Difficulty in Breathing
[] Hardening of Arteries
[] Phlebitis
[] Blood Clots
[] Cold hands/feet
[] Coronary Heart Disease
[] Palpitations
[] Irregular Heartbeat
[] Mitral Stenosis
[] Mitral Prolapse
[] Bleeding easily

Respiratory

[] Cough
[] Bronchitis
[] Difficulty breathing lying down
[] Emphysema
[] Coughing Blood
[] Pneumonia
[] Asthma
[] Pain w/ deep breath
[] Production of Phlegm
[] Pleurisy

Gastrointestinal

[] Nausea
[] Vomiting
[] Bad Breath
[] Abdominal Pain or Cramps
[] Indigestion
[] Ulcer
[] Constipation
[] Gas/Bloating
[] Blood in Stools
[] Rectal Pain
[] Chronic Laxative Use
[] Colitis
[] Diarrhea
[] Belching
[] Black Stools
[] Hemorrhoids
[] Acid Reflux
[] Vomiting/Spitting blood

Genitourinary

[] Bed Wetting
[] Urgent Urination
[] Bladder Infections
[] Prostate Problems
[] Blood in Urine
[] Kidney Infections / Stones
[] Genital Herpes
[] Cystitis
[] Frequent Urination
[] Painful Urination
[] Venereal Disease
[] Incontinence

Pregnancy and Gynecology

[ ] Number of Pregnancies
[ ] Number of Abortions
[ ] Number of Births
[ ] Number of Miscarriages
[] Use of Birth Control
[] Frequent changes in emotion
[] Hot Flash/Night Sweats
[] Osteoporosis
[ ] Age at 1st Menstruation
____ Time between Menstruation
____ Duration of Menstruation
____ First Date of Last Menstruation
[] Irregular Periods
[] Endometriosis
[] Uterine Fibroids
____ Age of Menopause
[] Menstrual Flow (heavy/light)
[] Color of Menses
[] Texture of Menses
[] Breast Lumps
[] Painful Periods/Cramps
[] Vaginal Discharge (Color)
[] Vaginal Sores

Musculoskeletal

[] Neck Pain
[] Muscle Weakness
[] Hand/Wrist Pain
[] Foot/Ankle Pain
[] Back Pain
[] Shoulder Pain
[] Hip Pain
[] Muscle Pains
[] Elbow Pain
[] Knee Pain

Neuropsychological

[] Seizures
[] Areas of Numbness
[] Concussion
[] Bad Temper
[] Difficulty Concentrating
[] Dizziness
[] Lack of Coordination
[] Depression
[] Easily susceptible to stress
[] Loss of Balance
[] Poor Memory
[] Anxiety
[] ADD

Infection

[] Measles
[] Rheumatic Fever
[] Malaria
[] Small Pox
[] Mumps
[] Tuberculosis
[] Chicken Pox
[] Whopping Cough
[] Typhoid Fever
[] Scarlet Fever

Others

Are you allergic to any of the following? (If yes, please specify)

( ) Medicine
( ) Food
( ) Herbs
( ) Others

Did you have or are you having any of the following?

( ) Pacemaker
( ) Electric Implants
( ) Metal Implants
( ) Severe Bleeding Disorders
( ) Pregnant
( ) HIV Positive
( ) Hepatitis A/B/C
( ) Others

Social History

	No	Yes	When Started	When Stopped	Amount
Coffee	___	___	_____	_____	_____
Tea	___	___	_____	_____	_____
Alcohol	___	___	_____	_____	_____
Tobacco	___	___	_____	_____	_____
Other	___	___	_____	_____	_____

Diet, Exercises and Life Style:

Family History (please include the relationship)

[] Migraines _____
[] Heart Disease _____
[] Allergies _____
[] Asthma _____
[] Arthritis _____
[] Diabetes _____
[] Glaucoma _____
[] Others _____

[] Stroke _____
[] High Blood Pressure _____
[] Mental Illness _____
[] Gall Stones _____
[] Cancer _____
[] Thyroid Disease _____
[] Epilepsy _____

Comments

Please tell us of any other problems you would like to discuss:

_____
_____
_____
_____
_____
_____
_____

Please inform us if you have
BLEEDING DISORDERS or ***PACEMAKERS*** or your are ***PREGNANT***
prior to receiving treatments!

In consideration of those who have fragrance sensitivities or allergies, please refrain from wearing scented products during your visit. Thank you.