Acu-ity Oriental Medicine, LLC
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Patient Information

Name____Date_____________________

Primary care physician (name, town, state, phone number)______________________________
____

Home address (street address, town, state, zip code)__________________________________

____

Phone (home)___________________________ (mobile)_______________________________
Daytime phone number____
Emergency contact (name, number, relationship to patient)______________________________
____
Age__________ Sex__________ Marital Status (S, M, W, D, domestic partner)_____________

Date of birth____________________ Place of birth_______________________
Children (age and sex)____
____
Current household members____

Chief Complaint

Medical issue for which you seek treatment today____________________________________

____
How long have you had above issue?____
On a scale of 1-5 (5 is most severe), how do you rate the issue?_________________________
Any other symptoms/causes related to the issue?______________________________________
____
List any other medical professionals from whom you have sought treatment for chief complaint?

____

Medical History

Height___________________ Weight____________________
Blood Pressure(if known)_______________ Blood sugar__________ Cholesterol__________

Medications (including vitamins, supplements) Please indicate if you are taking blood thinning medication____
____
____
____

____
____

Previous illnesses

____
____
____
____

Surgical procedures (type and date)

____
____
____

Female patients: Do you still have a menstrual period?_________ If no, age of menopause_________________
Male patients: Have you had a prostate exam? __________ If yes, date of most recent exam________________
Pain in head or body (location):____
____
Sleep (hours, quality):
____
Exercise:
____
Do you smoke? If yes, how long?
____
Alcohol or coffee consumption:____
Stress level: 1-5, 5 is highest (circle)
Stress from family 1 2 3 4 5
Stress from work 1 2 3 4 5
Emotion with which associate most (circle): anger, joy, overthinking, sadness, fear
Preferred taste (circle): sour, bitter, sweet, spicy, salty
Do you eat regular meals?_____________
What type of snacks do you eat and when?____
Lifestyle:
occupation:____

hobbies:____
social network:____

Family history (List all that apply)
hypertension stroke diabetes heart disease cancer (type) arthritis addiction (type) mental illness

mother	
father	
siblings	

grandparents	

Age of parents:______________________________

Mark symptoms with (+) if often, (√) if sometimes, blank if not at all (there may be overlap of symptoms, so please mark even if you see symptom twice). This grid is for your TCM diagnosis.

palpitations	irritability	shortness of breath	no appetite	overwork
shortness of breath	anger	cough	abdominal distention/bloating	congenital illness
night sweats	headache on side or top of head	spontaneous daytime sweating	fatigue	low back pain
spontaneous daytime sweating	dream disturbed sleep	dislike of cold	weak limbs	dizziness
light headedness	constipation	tendency to catch colds	loose stool	sexual dysfunction
dizziness	dark yellow urine	fatigue	nausea	hearing loss
insomnia	nose bleeds	low grade fever	chest tightness	achy bones
poor memory	tremors	dry mouth	edema	constipation
anxiety	high fever	chest tightness	cold limbs	cold knees
thirst	nausea	dry cough	bearing down sensation in abdomen	clear urine
tongue ulcers	ribside pain or discomfort	thirst	hemorrhoids	dribbling urination
depression	groin pain	feelings of grief	easy to bruise	cold hands and/or feet
cold sores	blurry vision	swelling in face	blood in urine or stool	ear wax
	muscle cramps	chronic cough	crave sweets	achy, heavy joints
	“floaters” in eyes	profuse white sputum	dark yellow urine	localized stabbing pain
	dry mouth	asthma		

Review of Western medicine symptoms: Please list all that apply

Skin (rashes, lumps, itch, moles that have changed, sores)	
Head/Eye/Ear/Nose/Throat	
Neck (swollen glands, lumps, pain, stiffness)	
Breast (lumps, pain, discharge)	
Respiratory (cough, sputum, asthma, bronchitis, emphasema, pneumonia, tuberculosis)	
Cardiovascular (palpitations, chest discomfort, murmurs, edema, high blood pressure)	
Gastrointestinal (trouble swallowing, heartburn, appetite, gas, belching, stool color, size, frequency, tarry stool, hepatitis, jaundice, gallbladder problems, abdominal pain, hemorrhoids, ulcers)	

Urinary (frequent urination, burning, nighttime urination, kidney stones, dribbling)	
Genital (birth control, menstrual disorders, menopausal symptoms, erectile dysfunction, BPH)	
Peripheral vascular (leg cramps, varicose veins, swelling in legs or feet, change in color of fingertips or toes in cold weather)	
Musculoskeletal (muscle, joint, gout, arthritis, back pain, weight loss)	
Psychological (nervousness, mood changes, depression, suicidal thoughts)	
Neurological (headache, tremors, changes in mood, attention or speech, dizziness, insomnia, numbness, fainting)	
Blood (bleeding, clotting disorders, anemia, bruising, past transfusions)	
Endocrine (thyroid, cold/hot intolerance, excessive sweating, excessive thirst or hunger, excessive urination, change in glove or shoe size, weight loss or gain)	
Allergies (type and duration)	
Pain Onset, Location, Characteristics (dull sharp, local, diffuse) Aggravate/alleviate/radiate scale of 1 to 5, 5 being highest	
Energy level (circle scale of 1-5)	1 2 3 4 5 (5 is highest), indicate if any issues at certain time of day

Any other symptoms/information you wish to discuss____________________________________

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