WEI'S CHINESE MEDICAL CENTER

6250 Lantana Rd, Suite 2, Lake Worth, FL 33463

Today's Date:_____

Name Last_____ First_____ **Date of Birth**_____ **Age**_____
Gender F ____M _____ **Marital Status:** ☐M ☐S ☐D ☐W Email _____
Address _____City _____State_____
Zip Code_____ **Telephone:** Cell Phone (_____) _____-_____
Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? We will not sell or give your email to any other agency. **Yes** _____ **No** _____

Optional: Height _____ Weight _____ HIV _____ HbsAg _____
How did you hear about our clinic or were you referred by someone? _____
Have you been treated by Acupuncture or Oriental medicine before? _____
Emergency Contact: Name_____ Phone: _____
Relationship _____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1. Main problem you would like us to help you with:

   _____
2. How long ago did this problem begin?

   _____
3. Have you been given a diagnosis for this problem? If so, what?

   _____
4. What kinds of treatment have you tried?

   _____

Are you currently receiving treatment for your problem? _____If so, please describe:

_____

5. Does anything improve your problem?

_____

PAST MEDICAL HISTORY

Illnesses: _____

_____

Surgeries_____

_____

Significant Trauma (Auto accidents, falls, etc.) _____

Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐ If so, please describe

_____

Medicines (prescription and over-the-counter drugs, vitamins, herbs, etc. taken within the last three months)

_____

_____

Allergies

_____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side_____
Father's Side_____
Siblings _____
If any of the above is deceased, what was the cause? _____

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.)_____
Childhood health _____
Current Emotional Health _____
Current Predominant Emotion_____
Occupation _____Stress Level _____
Have you had any unusual stresses recently?_____
Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe: _____
If applicable, please describe smoking or alcohol intake: _____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Areas of Numbness	☐ Anxiety
☐ Concussion	☐ Lack of Coordination	☐ Poor Memory
☐ Dizziness	☐ Loss of Balance	☐ Easily Angered
☐ Headaches	☐ Fainting	☐ Depression
☐ Migraines	☐ Disorientation	☐ Mania
☐ Easily Susceptible to Stress	☐ Others: _____	

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide?
_____
Any other neurological or psychological problems?
_____ Any nervous habits?
_____

PLEASE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST THREE (3) MONTHS)

GENERAL

☐ Fevers	☐ Tremors	☐ Change in Appetite
☐ Chills	☐ Seizures	☐ Peculiar tastes or smells
☐ Fatigue	☐ Night Sweats	☐ Sudden energy drops?
What time of Day? _____		☐ Strong thirst for Hot or Cold drinks?
☐ Poor Sleep/ Insomnia	☐ Day Sweating	☐ Headaches
☐ Dream Disturbed Sleep	☐ Poor Balance	☐ Localized Weakness
☐ Depression	☐ Weight Loss	☐ Bleeding or Bruising
☐ Mania	☐ Weight Gain	☐ Joint Pain
☐ Emotional Changes	☐ Poor Appetite	☐ Others:_____

CARDIOVASCULAR

☐ High blood pressure	☐ Dizziness	☐ Swelling of Hands	☐ Blood Clots
☐ Irregular heartbeat	☐ Fainting	☐ Difficulty in Breathing	☐ Palpitations
☐ Low blood pressure	☐ Cold Sweats	☐ Cold Hands/Feet	☐ Others:_____
☐ Chest pain	☐ Swelling of Feet	☐ Phlebitis	

RESPIRATORY

- Cough
- Pain w/ Deep Breaths
- Difficulty in Breathing
- Asthma
- Bronchitis
- Shortness of Breath
- Easily Winded w/ Exertion when laying down
- Coughing Blood
- Production of phlegm What color? _____
- Others:_____

GASTROINTESTINAL

- Nausea
- Abdominal Pain/ Cramps
- Digestive Disorders
- Vomiting
- Parasites
- Constipation
- Indigestion
- Belching
- Diarrhea
- Ulcers
- Bad Breath
- Blood in Stools
- Hernia
- Hemorrhoids
- Others:_____

GENITO-URINARY

- Pain on Urination
- Decrease in Urine
- Kidney sores
- Urgent Urination
- Blood in Urine
- Waking up to Urinate
- Frequent Urination
- Impotency/ Infertility

How often? _____

- Unable to Hold Urine
- Genital Sores
- Others:_____

MUSULOSKELETAL

- Muscular Weakness
- Arthritis
- Recent Sprains
- Muscle Cramps
- Spasms
- Others:_____
- Injuries or Falls
- Muscular Atrophy
- General Aches
- Joint Instability

FOR WOMEN ONLY

___Age at First Manses'
___Period between Manses'
___Duration of Manses'
Hysterectomy Yes No
 Heavy or Light
 Irregular Periods
 Painful Periods

__ Number of Pregnancies
__ Number of Births
__ Miscarriages
__Abortions
 Difficult Births
 Breast Lumps
 Clots

 Birth Control?
What type? _____
How long?_____
 Fertility Problems
 Vaginal Discharge
 Vaginal Sores
 Others:_____

First Date of Last Menstrual Cycle _____ Date of Last Pap Smear _____

Do you experience changes in Body and/or Psyche prior to menstruation? _____

Menstruation □ None (when stopped_____) □ Abdomen Pain □ Low Back Pain □ Breast Pain □ Excessive Amount □ Normal Amount □ Hot Flash □ Little Amount □ Clots □ Color:_____

□ Length of Periods _____days □ Length of each cycle ___ days

Other Symptoms:_____ STD (explain)_____

Discharge for Yeast Infection □ Color:_____ □ Amount:_____

Menopause □ Hot Flash □ Night sweating

Pregnancy □ Number of Pregnancies:_____□ Birth:_____□ Premature Birth:_____

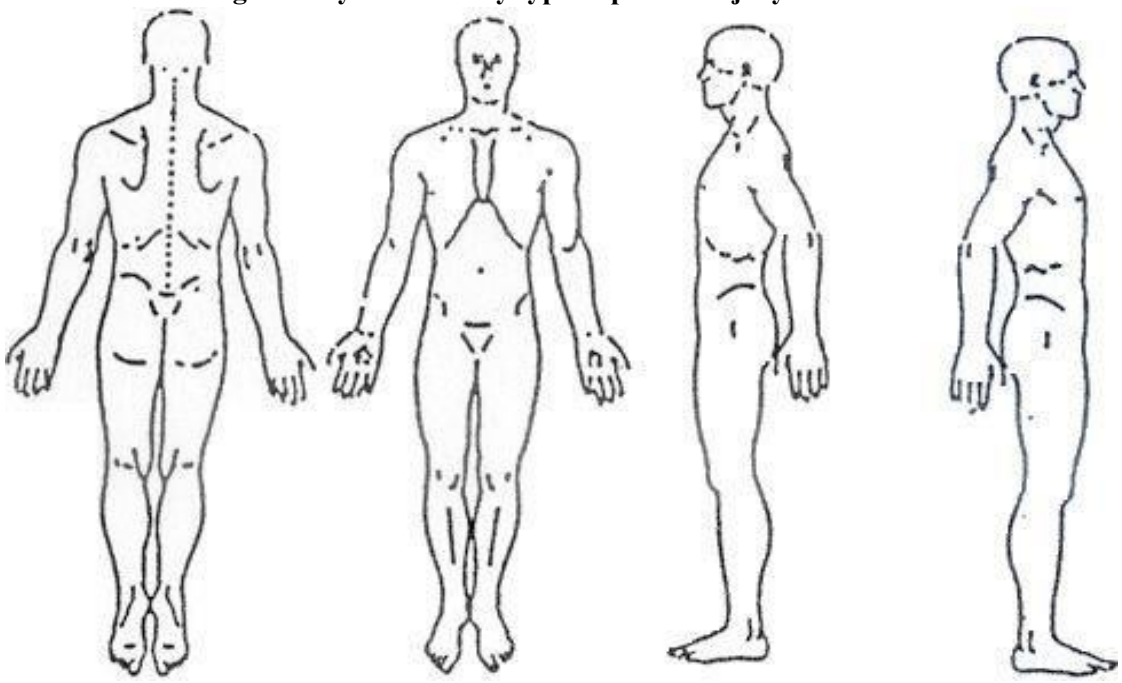
□ Abortion:_____□ Infertility: _____□ Miscarriage:_____

FOR MEN ONLY

□ Prostate Infection □ Prostate cancer □ Enlarged Prostate □ Impotency □ Yeast Infection

□ STD_____ □ Other_____

Please circle on the diagram any areas of any type of pain or injury:



Please try to describe the type and quality of the pain _____

Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain the most intense pain

Are there any other internal organ or systemic dysfunctions that we should be aware of? _____

_____

Are there any other problems you would like to discuss? _____

Consent for Acupuncture

I understand that acupuncture uses fine needles and related techniques to help improve health and relieve symptoms.
I understand that results vary and no guarantee has been made regarding outcomes.Possible side effects include mild soreness, bruising, fatigue, dizziness, or temporary discomfort; serious complications are rare. I have informed my practitioner of my medical conditions, medications, and pregnancy status if applicable. I voluntarily consent to receive acupuncture treatment and understand I may stop treatment at any time.

_____ _____

Patient's signature (Parent or Guardian if under 18) **Date**

Financial policy for services

I understand that I am financially responsible for all services rendered, including those not covered or reimbursed by insurance, and agree to pay all charges at the time of service.

_____ _____

Patient's signature (Parent or Guardian if under 18) **Date**