CONFIDENTIAL CASE HISTORY

NAME: LAST	FIRST	MIDDLE	SEX	AGE	BIRTH DATE	TODAY'S DATE

STREET ADDRESS	MARITAL 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 ☐	WORKER'S COMP ☐	OTHER ☐

STREET ADDRESS (IF DIFFERENT FROM PATIENT'S)	INSURANCE COMPANY	NO COVERAGE ☐

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? _____

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	☐	☐	hearing	☐	☐
moles	☐	☐	seeing	☐	☐
swelling	☐	☐	smelling	☐	☐
stiff joints	☐	☐	racing heart	☐	☐
dizziness	☐	☐	digestion	☐	☐
balance	☐	☐	weight	☐	☐
appetite	☐	☐	constipation	☐	☐
sleeping	☐	☐	mood or feelings	☐	☐
breathing	☐	☐	(women only)		
pains, aches	☐	☐	menstruation	☐	☐

Last medical examination: _____

Who is or was your regular doctor?

_____

City & State _____

Are you taking any medication? _____

Specify: _____

_____

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

	YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE
anemia	☐	☐	kidney or bladder trouble	☐	☐
asthma	☐	☐			
bleeding tendencies	☐	☐	mental disorder	☐	☐
cancer or tumor	☐	☐	rheumatism or arthritis	☐	☐
diabetes	☐	☐	stroke	☐	☐
epilepsy	☐	☐	tuberculosis	☐	☐
glaucoma	☐	☐			
gout	☐	☐	ulcer or stomach trouble	☐	☐
heart trouble	☐	☐	numbness	☐	☐
			sciatica	☐	☐
high blood pressure	☐	☐	headaches	☐	☐
scoliosis	☐	☐			

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 _____

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CONSULTATION HISTORY

HISTORY OF COMPLAINT (INJURY):

PRESENT COMPLAINTS:

PAST HISTORY:

WORKING DIAGNOSIS:

COMMENTS:

LITIGATION (ATTORNEY):