**Application for treatment**

*San Marcos Acupuncture Clinic and Wellness Center*

*1582 San Marcos Blvd. #101B, San Marcos, CA 92078, (760) 891-0900*

Today's Date _____

First Name: MI Last Name:

Address: City State Zip

Home Phone: ( ) Cell ( ) Work ( )

Birth Date: Age: ☐ Male ☐ Female

Name of Spouse/ Partner: Number of Children: Ages:

Social Security # : Drivers License # :

Employer: Occupation:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Other

Emergency Contact: Telephone ( )

E-mail address:

*Who will be responsible for your bill?*

☐Self ☐Spouse ☐Employer ☐Insurance ☐Other ☐Parent

*Method of Payment:*

☐Cash ☐Check ☐Credit Card ☐Health Insurance

☐Worker's Comp. ☐Auto.Insurance ☐Group insurance

*If Medical Insurance Card is not provided, then fill out:*

Name of Insured: Group #:

Relationship to Pt: ☐ Self ☐ Spouse ☐ Parent ☐ Child

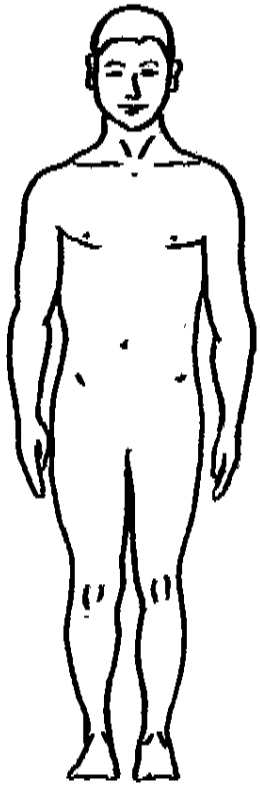
Insurance Company Name: ID#:

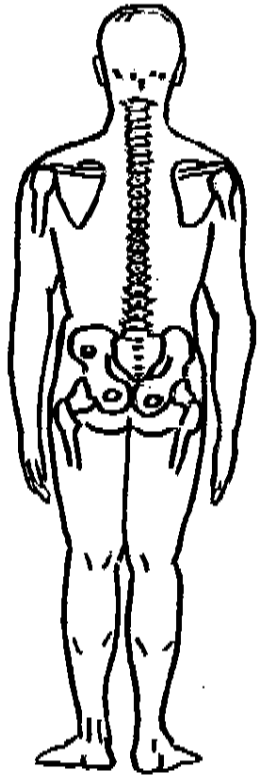
Insurance Company Address:

Secondary Insurance: Spouse Date of Birth:

*Patient Signature:* _____

**Main Complaint/s:** If you are in pain, please mark the location of the pain on the diagram below.





**When** did the problem/ condition start?

*What **Caused** this condition?*

☐Work Accident ☐Auto Accident ☐Fall ☐Repetitive Motion ☐Other

*What seems to make it **better**?*

☐Rest ☐Activity ☐Warm weather ☐Cold weather ☐ Massage/touch ☐Other

*What seems to make it **worse**?*

☐Night time ☐Daytime ☐ Rest ☐Activity ☐Heat ☐Cold ☐Touch ☐Other

Is this condition? ☐ Getting Worse or ☐ Staying the Same

Are you currently under the care of **another physician?** Yes No

For what condition?

Name of Physician: Tel. Number:

Have you ever received **other treatment** for this condition before? Yes No

When? What kind of treatment?

Have you ever had **Acupuncture** before? Yes No

Have you taken **Chinese Herbal Medicine** before? Yes No

**FAMILY MEDICAL HISTORY** (indicate Mother /Father /Sibling /*Grandparents*)

| | | | |
|---|---|---|---|
| ☐ Allergies | ☐ Cancer | ☐ Heart Disease | ☐ Osteoporosis |
| ☐ Asthma | ☐ Depression | ☐ High bloodpressure | ☐ Substance abuse |
| ☐ Arthritis | ☐ Diabetes | ☐ Migraines | ☐ Seizures/ Epilepsy |
| ☐ Alcoholism | ☐ Glaucoma | ☐ Mental Illness | |

**Past** *or* **Current** *Choose which apply :* PAST Medical History and/ or CURRENT Condition and Symptoms

| | | | |
|---|---|---|---|
| ☐ ☐ Allergies | ☐ ☐ Consume refined sugar Daily / regularly/ minimal | ☐ ☐ Lose temper easily | ☐ ☐ Strongly like Cold drinks |
| ☐ ☐ Alcoholism | ☐ ☐ Diabetes: *Type Since* | ☐ ☐ Light headed upon rising | ☐ ☐ Strongly like Hot drinks |
| ☐ ☐ Appendicitis | ☐ ☐ Dream disturbed sleep | ☐ ☐ Liver problems | ☐ ☐ Sweats easily |
| ☐ ☐ Anemia | ☐ ☐ Daily use artificial sweetener | ☐ ☐ Marijuana | ☐ ☐ Scarlet fever |
| ☐ ☐ Alcohol _____bottles/week | ☐ ☐ Difficulty in excess: lifting, Standing, walking, sitting, Twisting, household duties | ☐ ☐ Measles | ☐ ☐ Soft drinks _____/day |
| ☐ ☐ Birth trauma | ☐ ☐ Excessive thirst | ☐ ☐ Multiple sclerosis | ☐ ☐ Thirst for Water |
| ☐ ☐ Bodily heaviness | ☐ ☐ Excessive sweating | ☐ ☐ Mumps | ☐ ☐ Tobacco: Packs/wk _____ |
| ☐ ☐ Bleed & bruise easily | ☐ ☐ Eat Salty food: Daily/ Regularly / Minimally | ☐ ☐ Minimal exercise | ☐ ☐ Thyroid Disorders Since:_____ |
| ☐ ☐ Cancer (Since) | ☐ ☐ Fatique | ☐ ☐ Night sweat | ☐ ☐ Typhoid fever |
| ☐ ☐ Chicken Pox | ☐ ☐ Fever | ☐ ☐ Occupational hazards | ☐ ☐ Varicose veins |
| ☐ ☐ Chemotherapy (when) | ☐ ☐ Goiter | ☐ ☐ Poor sleeping/ Insomnia | ☐ ☐ Water_____glasses/day |
| ☐ ☐ Generally feel run down | ☐ ☐ Gout | ☐ ☐ Polio | ☐ ☐ Weight problems |
| ☐ ☐ Chills | ☐ ☐ Gallbladder problem | ☐ ☐ Peculiar taste in mouth | |
| ☐ ☐ Crave sweets or salt | ☐ ☐ Heavy sleep | ☐ ☐ Recent weight loss/gain | |
| ☐ ☐ Coffee _____cups/day | ☐ ☐ Lack of strength | ☐ ☐ Rheumatic Fever | |

Mayor Traumas: Fall/ Automobile Accident. When_____Where (At work?)_____

Allergies:_____

Surgical History: *Type of surgery & Date* _____

_____

Medications/ Supplements: _____

_____

## Head, Eyes, Ears, Nose & Throat

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ Blurred vision | ☐ ☐ Eye see Spots | ☐ ☐ Glaucoma | ☐ ☐ Headache: Temples | ☐ ☐ Recurrent Sore Throat |
| ☐ ☐ Contact Lenses | ☐ ☐ Eye bothered by light | ☐ ☐ Grinding teeth | ☐ ☐ Hayfever | ☐ ☐ Sores on Lips /Tongue |
| ☐ ☐ Cataract | ☐ ☐ Eye inflammation | ☐ ☐ Gum problems | ☐ ☐ Loss of smell | ☐ ☐Sore Mouth |
| ☐ ☐ Concussion | ☐ ☐ Eye sight poor | ☐ ☐ Hoarseness | ☐ ☐ Loss of taste | ☐ ☐Sinus problems |
| ☐ ☐ Double Vision | ☐ ☐ Ears Discharge | ☐ ☐ Hearing Loss R / L | ☐ ☐ Lump in throat | ☐ ☐Swallowing Difficulty |
| ☐ ☐ Difficult speech | ☐ ☐ Ear Pain/ Earaches | ☐ ☐ Hearing Poor R / L | ☐ ☐ Lymphnodes Swollen | ☐ ☐TMJ R / L |
| ☐ ☐ Dry Mouth | ☐ ☐ Ear infection | ☐ ☐ Head seems too heavy | ☐ ☐ Migraines | ☐ ☐Tinnites (ear ringing) R / L |
| ☐ ☐ Eye Pain | ☐ ☐ Excessive Saliva | ☐ ☐ Headache: Light | ☐ ☐ Nose Bleeding | ☐ ☐Vertigo |
| ☐ ☐ Eye Strain | ☐ ☐ Enlarged Thyroid | ☐ ☐ Headache: entire head | ☐ ☐ Nose Pain | |
| ☐ ☐ Eye Red | ☐ ☐ Facial Pain | ☐ ☐ Headache:back of head | ☐ ☐ Night Blindness | |
| ☐ ☐ Eye Itchy | ☐ ☐ Glasses | ☐ ☐ Headache: forehead | ☐ ☐ Night Vision Poor | |

## Gastro-Intestinal (Stomach/Bowels)

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ Acid Regurgitation (heartburn) | ☐ ☐ Black stools | ☐ ☐ Eating disorder | ☐ ☐ Itchy anus | ☐ ☐ Nausea |
| ☐ ☐ Abdominal pain | ☐ ☐ Bloody stools | ☐ ☐ Excessive Gas | ☐ ☐ Infrequently stools | ☐ ☐ Nervous Stomach |
| ☐ ☐ Anal fissures | ☐ ☐ Burning anus | ☐ ☐ Gas | ☐ ☐ Intestinal Pain | ☐ ☐ Rectal pain |
| ☐ ☐ Bloating | ☐ ☐ Constipation | ☐ ☐ Hiccup | ☐ ☐ Indigestion | ☐ ☐ Ulcers |
| ☐ ☐ Belching after meals | ☐ ☐ Difficulty chewing | ☐ ☐ Hemorrhoids | ☐ ☐ Laxative usage | ☐ ☐ Vomiting food |
| ☐ ☐ Bad breath | ☐ ☐ Diarrhea | ☐ ☐ Intestinal cramping | ☐ ☐ Mucous in stool | ☐ ☐ Vomiting blood |

## Cardiovascular / Heart

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ AICD | ☐ ☐ Chest Pain | ☐ ☐ Heart Palpitations | ☐ ☐ Low Blood Pressure | ☐ ☐ Swollen hands & feet |
| ☐ ☐ Arteriosclerosis | ☐ ☐ Cold hands & feet | ☐ ☐ Heart Disease | ☐ ☐ Pacemaker | ☐ ☐ Tachycardia |
| ☐ ☐ Bloodclots | ☐ ☐ Difficulty Breathing | ☐ ☐ High Blood Pressure | ☐ ☐ Poor circulation | |
| ☐ ☐ Cholesterol High | ☐ ☐ Fainting | ☐ ☐ Irregular Heartbeat | ☐ ☐ Phlebitis | |

## Infection / Venereal diseases

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ Chlamydia | ☐ ☐ Genital Warts | ☐ ☐ AIDS | ☐ ☐ Herpes Genital | ☐ ☐ Tuberculosis |
| ☐ ☐ Gonorrhea | ☐ ☐ HIV *since* | ☐ ☐ Herpes oral | ☐ ☐ Hepatitis *Since* | ☐ ☐ Syphilis |

## Genito-urinary

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ Blood in urine | ☐ ☐ Excessive urination | ☐ ☐ Kidney stone | ☐ ☐ Pain / swelling in genitals | ☐ ☐ Urgent urination |
| ☐ ☐ Bedwetting | ☐ ☐ Frequent urination | ☐ ☐ Lump in testicles *Male* | ☐ ☐ Premature Ejaculation | ☐ ☐ Unable to hold urine |
| ☐ ☐ Cold & numb feeling in genitals | ☐ ☐ Incomplete urination | ☐ ☐ Lesion / discharge from genitals | ☐ ☐ Pain during urination | ☐ ☐ Venereal disease |
| ☐ ☐ Discolored urine | ☐ ☐ Increased Libido | ☐ ☐ Nocturnal emission | ☐ ☐ Pain/ itching genitals | ☐ ☐ Wake to urinate: Times/night_____ |
| ☐ ☐ Decreased Libido | ☐ ☐ Impotence *Male* | ☐ ☐ Prostate problems | ☐ ☐ Scanty urination | ☐ ☐ Weak urinary stream |

## Musculoskeletal

| **Neck** | | **Hands** | | ☐ Can't raise arm above shoulder | **Hip** | | **Knee** | |
|---|---|---|---|---|---|---|---|---|
| Stiff neck | R / L | Sensation of Pins & Needles in Fingers | R / L | ☐ Head& shoulders tired | Arthritis of Hip | R / L | Pain in Knee | R / L |
| Grinding Sounds in neck | R / L | Pain in Hands | R / L | Frozen shoulder R / L | Previous hip surgery | R / L | Cold Knees | R / L |
| Grating sounds in neck | R / L | Pain in Fingers | R / L | Traumatic shoulder injury R / L | Pain in hip joint | R / L | Previous Knee Surgery | R / L |
| Neck muscles spasm | R / L | Cold hands | R / L | *Other* | Pain in Buttocks | R / L | *Other* | |
| Arthritis in neck | R / L | Swollen Joints in Fingers | R / L | | Osteoporosis | R / L | **Feet** | |
| Previous neck injury | R / L | Sore Joints in Fingers | R / L | **Lumbar & whole back** | *Other* | | Cramps in feet | R / L |
| *Other* | | Loss of Grip strength | R / L | ☐ Low back pain (LBP) | | | Feet feel cold | R / L |
| **Arms** | | *Other* | | ☐ LBP since _____ | **Leg** | | Numbness of feet | R / L |
| Arthritis in _____ | R / L | | | ☐ Pain in sacrum | Pain on Side of Leg | R / L | Pain in Foot | R / L |
| Sensation of *numbness* Where? | R / L | **Shoulder** | | ☐ Pain in coccyx | Pain down the leg | R / L | Swollen ankles | R / L |
| Sensation of Pins & Needles in arm | R / L | Arthritis | R / L | ☐ Pain between Scapulas | Pins & Needles in Legs | R / L | Wearing Heel lifts/ Arch supports | R / L |
| Sensation of Pins & Needles in arm | R / L | Bursitis | R / L | Laminectomy R / L | Upper Leg cramps | R / L | Numbness of toes | R / L |
| Pain in Upper Arm | R / L | **Shoulder Pain:** Constant / Intermittent | R / L | ☐ Whole Back Pain | Calf cramps | R / L | Painful joints in toes | R / L |
| Pain in Forearm | R / L | Shoulder pain at *night* | R / L | ☐ Back Curvature (Scoliose) | Pain in Upper leg | R / L | *Other* | |
| Pain in Elbow | R / L | Tension in shoulder | R / L | ☐ Back Curvature (Kifose) | *Other* | | **General** | |
| *Other* | | ☐ Pain across shoulder | | ☐ Back Curvature ( Lordosis) | | | ☐ Muscle twitching/spasm | |

## Neuropsychological

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ Anxiety | ☐ ☐ Dyslexia | ☐ ☐ Learning Disability | ☐ ☐ Nervous | ☐ ☐ Seeing a therapist |
| ☐ ☐ Abuse survivor | ☐ ☐ Epilepsy | ☐ ☐ Mood changes | ☐ ☐ Paralysis | ☐ ☐ Epilepsy Since_____ |
| ☐ ☐ Convulsions / Seizures | ☐ ☐ Easily stressed | ☐ ☐ Mistaking sidedness (R from L) | ☐ ☐ Poor memory | ☐ ☐ Tremors |
| ☐ ☐ Considered/attempted Suicide | ☐ ☐ Forgetfulness | ☐ ☐ Mental or emotional disorder | ☐ ☐ Memory loss | ☐ ☐ Tension |
| ☐ ☐ Depression | ☐ ☐ Fainting | ☐ ☐ Medicated Pain | ☐ ☐ Stroke | ☐ ☐ Trouble concentrating |
| ☐ ☐ Dizzyness | ☐ ☐ Irritability | ☐ ☐ Numbness | ☐ ☐ Stutter | |

## Respiratory/ Lungs

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ Asthma | ☐ ☐ Cough is dry | ☐ ☐ COPD | ☐ ☐ Pain in ribs | ☐ ☐ Phlegm Thin |
| ☐ ☐ Bronchitis | ☐ ☐ Coughing blood | ☐ ☐ Difficulty breathing | ☐ ☐ Pleurisy | ☐ ☐ Shortness of Breath |
| ☐ ☐ Cough | ☐ ☐ Cough/sneeze with pain | ☐ ☐ Difficulty breathing when Lying | ☐ ☐ Pneumonia | ☐ ☐ Tuberculosis |
| ☐ ☐ Cough persistent | ☐ ☐ Cold/flu frequently | ☐ ☐ Emphysema | ☐ ☐ Phlegm Excessive | ☐ ☐ Tight chest |
| ☐ ☐ Coughing Phlegm | ☐ ☐ Color of phlegm_____ | ☐ ☐ Lung problems | ☐ ☐ Phlegm Thick | ☐ ☐ Wheezing |

## Gynecology (menses/ Menstruation)

*Past or Current*

| | | | | |
|---|---|---|---|---|
| Number or live births _____ | Number of Abortions _____ | ☐ ☐ Breast discharge | ☐ ☐Menses: decreased bleeding | ☐ Premature Births |
| Age menses began _____ | Number of Pregnancies _____ | ☐ ☐ Bleeding between periods | ☐ ☐ Menopausal problems | ☐ ☐ Regular 28 day cycle |
| Vaginal Discharge Color _____ | ☐ Currently pregnant | ☐ ☐ Cramping with period | ☐ ☐ Pain during Intercourse | ☐ ☐ Urinary tract infections frequently |
| Duration of Flow_____days | ☐ ☐ Breast Distention | ☐ ☐ Difficulty with Orgasm | ☐ ☐ Painful Periods | ☐ ☐ Vaginal discharge |
| Date of last Period _____ | ☐ ☐ Breast Soreness/Pain | ☐ ☐ Hot flushes | ☐ ☐ PMS | ☐ ☐ Vaginal Sores |
| Length of Cycle _____days | ☐ ☐ Breast Lumps | ☐ ☐ Irregular Periods | ☐ ☐ Papsmear abnormal | ☐ ☐ Vaginal Odor |
| Menses: Color _____ | ☐ ☐ Bloodclots | ☐ ☐ Menses: excess bleeding | ☐ ☐ Pelvic inflammatory disease | ☐ ☐ Vaginal infections frequent |

## Skin & Hair

*Past or Current*

| | | | | |
|---|---|---|---|---|
| ☐ ☐ Acne | ☐ ☐ Dry scalp /Dandruff | ☐ ☐ Hair loss | ☐ ☐ Hives / Itching / Rashes | ☐ ☐ Psoriasis |
| ☐ ☐ Cancer Skin | ☐ ☐ Eczema | ☐ ☐ Hair texture changed | ☐ ☐ Herpes Zoster | ☐ ☐ Pimples |
| ☐ ☐ Dryness Skin | ☐ ☐ Fungal infection | ☐ ☐ Hair graying (age)___ | ☐ ☐ Lumps/ Tumor | ☐ ☐ Ulcerations |

**Patient signature:**_____ **Date:**_____