

# CHINESE MEDICINE FOR HEALTH

## Patient Information Sheet

(Please write neatly or print and complete as much as possible)

Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Employed By \_\_\_\_\_ Business Address \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of last physical \_\_\_\_\_  
Your weight \_\_\_\_\_ Your height \_\_\_\_\_ Do you smoke? \_\_\_\_\_ Do you drink? \_\_\_\_\_

### Reason for visit and present symptoms:

\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking medication: ( ) Yes ( ) No Please list:

\_\_\_\_\_

Please list any allergies to medication: \_\_\_\_\_

Other allergies: \_\_\_\_\_

### Have you had before or currently have any of the following: (please circle)

Hypertension	Heart Disease	High Cholesterol	Stroke	Abnormal Bleeding
Seizures	Diabetes	Thyroid Problem	Cancer	Migraine Headaches
Anemia	Peptic Ulcer	Cirrhosis	Hepatitis	Tuberculosis
Head injury	HIV Positive	Schizophrenia	Depression	
Other				
History of Surgeries				

\_\_\_\_\_

Do your relatives have any of the above? ( ) Yes ( ) No Please specify:

\_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ When \_\_\_\_\_ Why \_\_\_\_\_

### Activities:

#### Please circle

Reading	Writing	Art	Music	Computer	Sewing	Hunting	Flying	Golfing
Tennis	TV	Swimming	Jogging	Walking	Cards	Dancing	Tai Chi	Aerobics
Biking	Other							

Have you seen other Alternative Therapists? \_\_\_\_\_ Type of Therapy \_\_\_\_\_

When \_\_\_\_\_, Result \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please sign here \_\_\_\_\_ Date: \_\_\_\_\_