

PATIENT CONFIDENTIAL INFORMATION

This confidential questionnaire will help us to determine the best treatment plan for you. If you have any questions, please feel free to ask. Thank you.

PERSONAL INFORMATION

Date: _____

Name (please print): _____

Home Address: _____

City: _____ State: _____ Zip: _____ CA Driver's License No.: _____

Phone: (H) _____ (W) _____ (CP) _____

Email: _____ Fax: _____

Occupation: _____ Employer: _____ Social Security No.: _____

Gender: ___ Male ___ Female Date of Birth: ____/____/____ Age: _____

Marital Status: ___ M ___ S ___ D ___ W No. of Children: _____

Emergency Contact person: _____ Phone #: _____

How did you find out about us? (Please check) ___ Acufinder ___ Friends ___ Family member their name _____
___ Center for Massage ___ Window sign ___ Ins. Co. (BC/BS/ASHP/UHC/others: please specify: _____

Have you received acupuncture therapy before? ___ Yes ___ No If yes, where? _____

Who is responsible for your account: (Please check that all applies) ___ Myself ___ Insurance ___ others (be specify)

INSURANCE INFORMATION

Primary

2ndery

Insurance co.	_____	_____
Insured name	_____	_____
Relationship with you	_____	_____
Effective date	_____	_____
Insured ID # / Group #	_____	_____
Insured DOB	_____	_____
Contact numbers	_____	_____
Effective Date	_____	_____
Deductible / Co-pay	_____	_____
Limitations	_____	_____

Medication Information:

Please list the medication you are currently taking: ___ Coumadin ___ Aspirin ___ others

Reason	Name	Dosage	Starting date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



LILY'S TCM CENTER

Lily Chang L.Ac.
Tel.: (619) 871-6068
Fax: (413) 751-0277

General info: Height __ ft __ in/cm Weight _____lb/kg BP ____/____mmHg HR ____/min TM:____F/CO

What's the main concern brought you here today? _____

Do you have any other health problems besides on the main concern? _____

Please list any allergies, food sensitivities, or food cravings that you have: _____

Please list any accidents, surgeries, or hospitalizations indicate dates:

<u>Family / Medical Hx</u>	<u>Self</u>	<u>Parents</u>	<u>Grant parents</u>	<u>Siblings</u>	<u>Kids</u>
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____
Seizure	_____	_____	_____	_____	_____
Rheumatic Fever	_____	_____	_____	_____	_____
Infectious disease	_____	_____	_____	_____	_____
Emotional disorders	_____	_____	_____	_____	_____
Others	_____	_____	_____	_____	_____

The diet info is optional for weight lose program:

Diet Info.	Contents	From	To
Breakfast	_____	_____	_____
Lunch	_____	_____	_____
Dinner	_____	_____	_____
Snacks	_____	_____	_____



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Please mark the following list of symptoms according to frequency

(: never experienced √: sometimes experienced +/++/+++ : frequently experienced)

- Lack of appetite
- Excessive appetite
- Vomiting
- Belching or burping
- Heartburn
- Excessive fullness
- Indigestion of oily foods
- Abdominal Pain
- Loosen stool or diarrhea
- Light colored stool
- Blood in stool
- Black “tarry” stool
- Constipation
- Colitis or diverticulitis
- Hemorrhoids

- Insomnia
- Heart palpitations
- Cold hands and feet
- Nightmares
- Mentally restless
- Laughing for no apparent reason
- Angina pains

- Easily sick
- Intolerance to weather changes
- Allergies
- Hay fever
- Cough
- Shortness of breath
- Bronchitis
- Asthma
- Chest pain
- Decreased sense of smell
- Nasal problems
- Skin problems
- Claustrophobia
- Recent use of antibiotics

- Eye problems
- Jaundice
- Hepatitis
- Gallstones
- Soft or brittle nails
- Easily angered
- Difficulty making plans or decisions
- Muscle spasms

- Lower back pain
- Knee problems
- Sciatic pain
- Hearing impairment
- Tetanus
- Decreased sex drive
- Hair loss
- Kidney stones

- Urinary problems

 - Fatigue
 - Edema
 - Easily bruised
 - Difficulty stopping bleeding
 - Headaches
 - Dizziness
 - Fainting easily
 - High blood pressure
 - High cholesterol
 - Sudden weight loss
 - Sudden weight gain
 - Easily obsessive
- Other: _____

Men only:

- Prostate problems
 - Painful or burning urination
 - Pain or coldness of genitals
- Other: _____

Women only:

- Pre-menstrual pain or discomfort sharp dull
- Menstrual pain or discomfort sharp dull
- Irregular menstrual cycle
- Swelling or pain in breasts
- When was your first period: _____ year old
- How long is your period: _____ weeks
- What’s your period duration: _____ days
- When was your last period: _____(MM/YY)
- Blood amount is: Heavy Middle light
- Blood color is: dark Middle light
- Are you currently pregnant? Yes No
- Last gynecology exam: _____
- Results: _____

Lifestyles:

- Tea _____
- Coffee _____
- Tobaccos _____
- Alcohol _____
- Drugs _____
- Exercises _____

Frequencies:

How do you FEEL about your life?

- Spouse or significant other: _____
- Family: _____
- Sex: _____
- Work: _____
- Yourself: _____



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