

**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:

<b>Diet Info.</b>	<b>Contents</b>	<b>From</b>	<b>To</b>
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

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

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- 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

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

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

- Urinary problems

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  - 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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