

*Dragon Rises College of Oriental Medicine*

352-371-2833  
www.dragonrises.edu

**PATIENT INFORMATION**

Name		Date		
Home Address				
City	State	Zip	Phone	
E-mail Address			Cell Phone:	
Business Address				
City	State	Zip	Phone	
Occupation				
Place of Birth				
Date of Birth	Age	Height	Weight	Soc. Sec. #
Sex	Marital Status (Single, Married, Life Partner, Divorced, Widowed)			

**In Case of Emergency Notify**

How did you hear of this office?  
Have you ever before tried acupuncture or Chinese herbal medicine?

**CHIEF COMPLAINT**

What are the main health problems for which you are seeking treatment?  
Please rate the extent to which your current complaint affects your daily life (1 = minor; 10 = major)  
Please rate your commitment to resolving this problem (1 = minor; 10 = major)  
What other forms of treatment have you sought?

**PAST MEDICAL HISTORY (check all which apply)**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Seizures	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Birth Trauma
<input type="checkbox"/> Vaccinations	<input type="checkbox"/> Childhood Illnesses	<input type="checkbox"/> Accidents
<input type="checkbox"/> Significant Trauma	<input type="checkbox"/> Medications	<input type="checkbox"/> Other (please specify)

**FAMILY MEDICAL HISTORY (check all which apply and specify which blood relative)**

<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Emotional Disorder
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other (please specify)	

**LIFESTYLE (please indicate the use and frequency of the following)**

<input type="checkbox"/> Coffee	<input type="checkbox"/> Black Tea	<input type="checkbox"/> Tobacco
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Caffeinated Beverages	<input type="checkbox"/> Recreational Drug
<input type="checkbox"/> Exercise (please specify type)		

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**MEDICATIONS**

Please list any medications and/or supplements you are currently taking

**GENERAL HEALTH** (please check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Poor Appetite       | <input type="checkbox"/> Disturbed Sleep     | <input type="checkbox"/> Insomnia               |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Poor Coordination   | <input type="checkbox"/> Weight Gain            |
| <input type="checkbox"/> Cold Hands and Feet | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Cold Abdomen           |
| <input type="checkbox"/> Tremors             | <input type="checkbox"/> Large Appetite      | <input type="checkbox"/> Localized Weakness     |
| <input type="checkbox"/> Strong Thirst       | <input type="checkbox"/> Weight Loss         | <input type="checkbox"/> Fevers                 |
| <input type="checkbox"/> Poor Balance        | <input type="checkbox"/> Bruise/Bleed Easily | <input type="checkbox"/> Sweat Easily           |
| <input type="checkbox"/> Cravings            | <input type="checkbox"/> Chills              | <input type="checkbox"/> Sudden Energy Drop     |
| <input type="checkbox"/> Soft/Brittle Nails  | <input type="checkbox"/> Catch Colds Easily  | <input type="checkbox"/> Other (please specify) |

**SKIN AND HAIR**

- |                                      |                                       |   |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Itching      | <input type="checkbox"/> Dandruff               |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Redness      | <input type="checkbox"/> Eczema                 |
| <input type="checkbox"/> Psoriasis   | <input type="checkbox"/> Hair Loss    | <input type="checkbox"/> Hives                  |
| <input type="checkbox"/> Pimples     | <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Other (please specify) |

**HEAD, EYES, EARS, NOSE, THROAT**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Eye Pain               | <input type="checkbox"/> Blurred Vision         |
| <input type="checkbox"/> Floaters             | <input type="checkbox"/> Spots in Eyes          | <input type="checkbox"/> Night Blindness        |
| <input type="checkbox"/> Ringing in Ears      | <input type="checkbox"/> Poor Hearing           | <input type="checkbox"/> Earaches               |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Sores on Lips/Tongue | <input type="checkbox"/> Dry Mouth/Throat       | <input type="checkbox"/> Bleeding Gums          |
| <input type="checkbox"/> Nosebleeds           | <input type="checkbox"/> Facial Pain            | <input type="checkbox"/> Jaw Clicking           |
| <input type="checkbox"/> Toothaches           | <input type="checkbox"/> Other (please specify) |   |

**CARDIOVASCULAR**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> High Blood Pressure    |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Cold Hands/Feet        |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Blood Clots            |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Palpitations           | <input type="checkbox"/> Other (please specify) |

**RESPIRATORY**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cough                                | <input type="checkbox"/> Coughing Blood      | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Bronchitis                           | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Coughing Phlegm        |
| <input type="checkbox"/> Pain with deep breath                | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nasal Congestion       |
| <input type="checkbox"/> Difficulty breathing when lying down |  | <input type="checkbox"/> Other (please specify) |

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**GASTROINTESTINAL**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Vomiting                     | <input type="checkbox"/> Diarrhea               |
| <input type="checkbox"/> Constipation       | <input type="checkbox"/> Gas                          | <input type="checkbox"/> Bloating               |
| <input type="checkbox"/> Belching           | <input type="checkbox"/> Abdominal Pain/Cramps        | <input type="checkbox"/> Indigestion            |
| <input type="checkbox"/> Heartburn/Reflux   | <input type="checkbox"/> Retention of Food in Stomach | <input type="checkbox"/> Lack of Appetite       |
| <input type="checkbox"/> Excessive Appetite | <input type="checkbox"/> Rectal Pain                  | <input type="checkbox"/> Black Stools           |
| <input type="checkbox"/> Blood in Stool     | <input type="checkbox"/> Hemorrhoids                  | <input type="checkbox"/> Bad Breath             |
| <input type="checkbox"/> Sensitive Abdomen  | <input type="checkbox"/> Chronic Laxative Use         | <input type="checkbox"/> Other (please specify) |

**GENITO-URINARY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain on Urination          | <input type="checkbox"/> Frequent Urination     | <input type="checkbox"/> Blood in Urine    |
| <input type="checkbox"/> Urgency to Urinate         | <input type="checkbox"/> Unable to Hold Urine   | <input type="checkbox"/> Kidney Stones     |
| <input type="checkbox"/> Decrease in Urine Flow     | <input type="checkbox"/> Impotence              | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Waking at Night to Urinate | <input type="checkbox"/> Other (please specify) |  |

**REPRODUCTIVE/GYNECOLOGICAL**

- |   |   |   |
|---|---|---|
| Age of 1 <sup>st</sup> Period _____                   | Age at menopause _____                                | # Pregnancies _____                             |
| # Live Births _____                                   | # Premature Births _____                              | # Miscarriages/Abortions _____                  |
| # days between periods _____                          | # days of flow _____                                  | Color of blood _____                            |
| <input type="checkbox"/> Clots (Color _____)          | <input type="checkbox"/> Painful Menses               | <input type="checkbox"/> Irregular Menses       |
| <input type="checkbox"/> Premenstrual Symptoms        | <input type="checkbox"/> Strong Menstrual Odor        | <input type="checkbox"/> Vaginal Discharge      |
| <input type="checkbox"/> Vaginal Odor                 | <input type="checkbox"/> Vaginal Dryness              | <input type="checkbox"/> Fibroids               |
| <input type="checkbox"/> Breast Lumps/Swellings       | <input type="checkbox"/> Endometriosis                | <input type="checkbox"/> Ovarian Cysts          |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Urinary Tract Infection      | <input type="checkbox"/> Hot Flashes            |
| <input type="checkbox"/> Decreased Sex Drive          | <input type="checkbox"/> Positive Mammogram/Pap Smear | <input type="checkbox"/> Other (please specify) |

**MUSCULO-SKELETAL**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Neck Pain       | <input type="checkbox"/> Back Pain                                  | <input type="checkbox"/> Knee Pain     |
| <input type="checkbox"/> Muscle Pain     | <input type="checkbox"/> Foot/Ankle Pain                            | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Hip Pain        | <input type="checkbox"/> Hand/Wrist Pain                            | <input type="checkbox"/> Sciatica      |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Other Joint/Bone Problems (please specify) |  |

**NEURO-PSYCHOLOGICAL**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Seizures                       | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Loss of Balance        |
| <input type="checkbox"/> Areas of Numbness              | <input type="checkbox"/> Poor Memory     | <input type="checkbox"/> Lack of Coordination   |
| <input type="checkbox"/> Concussion                     | <input type="checkbox"/> Depression      | <input type="checkbox"/> Anxiety                |
| <input type="checkbox"/> Bad Temper                     | <input type="checkbox"/> Easily Stressed | <input type="checkbox"/> Attempted Suicide      |
| <input type="checkbox"/> Treated for Emotional Problems |  | <input type="checkbox"/> Other (please specify) |