Dragon Rises College of Oriental Medicine
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Patient Information Form

Please complete this form in either blue or black ink only.

Name: _____ Date: _____

Address: _____City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Business Address: _____ City: _____ State & Zip:_____

Place of Birth: _____ Date of Birth: _____ Age: _____ Height:_____ Weight: _____

Biological (Birth) Sex: _____ Relationship Status: (Single, Married, Divorced, Widowed, Other:_____)

Contact In Case of Emergency:

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our clinic? _____

When and where did you last receive health care? _____
_____

Have you utilized acupuncture and Chinese medicine previously to coming to our clinic? Yes No

Do you have an reason to believe you may be pregnant? Yes No If so, how far along are you? _____

Do you have any infectious diseases? Yes No If yes, please identify the condition: _____

Has your medical case been referred to an attorney? Yes No

Please list your primary health complaints/concerns. Please rate the extent to which your current complaints affect your daily life (1=minor, 10=major): _____
_____
_____

Please rate your commitment to resolving your problems (1=minor, 10=major): _____
_____

Please list any medications (including natural remedies) you are currently taking or attach a list: _____
_____
_____
_____

Please list any known allergies or sensitivities to food, herbs, or medications: _____
_____
_____
_____

List any and all previous "significant health events" in chronological order (include surgeries, traumas, illnesses):

Health Event *Ex. Concussion from bicycle accident*	**Age Occurred** *5 years old*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

General Health Assessment: Please check those symptoms that apply. Please include all symptoms or conditions that you suffer from, including those you are currently taking medications for. *Example: if you take a drug for hypertension and even though it is controlled, please include that as one of your complaints.*

Family's Medical History Only:
(Please indicate just your family history of diseases below, not your current history)

___ Alcoholism
___ Asthma
___ Allergies/Hay fever
___ Cancer
___ Degenerative conditions (MS, etc)
___ Diabetes
___ Heart disease
___ Hepatitis
___ High Blood Pressure
___ Infectious disease
___ Kidney disease
___ Lyme disease
___ Mental illness: _____
___ Rheumatic Fever
___ Parkinson's disease
___ Seizures
___ Stroke
___ Thyroid disorders
___ Tuberculosis
___ Venereal disease
___Other family illnesses:_____
_____

Please fill out the next section as thoroughly as possible. Speak to other family members. This information may come as family anecdotes.

Personal Birth-Childhood History:

___ Alcohol/drugs used by mother prior or during pregnancy
___ Alcohol/drugs used by father prior to pregnancy
___ Mother and/or father exposed to toxins before conception or during pregnancy
___ Venereal disease by mother or father prior to pregnancy
___ Emotional or physical trauma suffered by mother during pregnancy
___ Illness of mother during pregnancy. (Please list): _____
_____
___ Poor nutrition by mother prior or during pregnancy
___ Medication used by mother during pregnancy (Please list): _____
_____
___ Mother smoked or exposed to second hand smoke
___ Prior miscarriage by mother before pregnancy: _____
_____
___ Late delivery
___ Premature delivery
___ Rapid labor by mother
___ Slow, long labor by mother
___ Induction of labor
___ Epidural by mother during labor
___ High forceps
___ Breech birth
___ Cord wrapped around neck
___ Cesarian section
___ Placenta previa
___ Birth weight in lbs: _____
___ Spent time in incubator after birth
___ Jaundiced as an infant
___ Mother hospitalized after childbirth beyond usual post-delivery
___ Bottle-fed
___ Breastfed by mother
___ Colic
___ APGAR score _____
Number of siblings: _____
Position among your siblings: _____
___ Health during childhood (good, fair, poor) _____
___ Slow or delayed development
___ Childhood obesity
___ ADD/ADHD
___ Hyperactivity
___ Learning disabilities: _____
_____
___ Physical, emotional, sexual abuse
___ Sleep patterns during childhood: ____
_____
___ Illnesses or hospitalizations in childhood: _____
___ Vaccine reactions: _____

Birth, Infancy, & Childhood History Details

*Please provide as much information as possible regarding any of the above checked conditions or other physical or emotional health related matters from your **birth or childhood**. Many current health conditions have their roots in events that occurred during the formative years of life and this information can be extremely valuable in your assessment and treatment. Much of this information may come as family anecdotes. Talk to family members to help fill in gaps and gather as much data as possible from this time of life.*

Ears, Eyes, & Mouth Health:
___ Ear discharge
___ Ear pain
___ Ear infection history: _____
___ Hearing loss
___ Ringing in the ears (tinnitus)
___ Cataracts
___ Conjunctivitis
___ Dry, itchy, watery eyes
___ Double Vision
___ Eye stress, easily fatigued
___ Floaters (spots in visual field). *Please list color and shape:* _____
_____
___ Glaucoma
___ Glasses/contacts: _____
___ Grit or stickiness to the eyes
___ Macular degeneration
___ Styes
___ Bleeding Gums
___ Blisters or canker sores
___ Gingivitis/gum disease
___ Other: _____

Hair, Nail, & Skin Health:
___ Brittle or dry hair
___ Dandruff
___ Hair loss (alopecia)
___ Nail fungus (hands or feet)
___ Poor nail health or other irregularities
___ Acne
___ Boils
___ Body odor
___ Cancers (melanoma, basal, etc)
___ Cold sores (herpes simplex)
___ Dry skin
___ Excessive perspiration
___ Hives or rashes
___ Itching skin
___ Lipomas (fatty tissue growths)
___ Moles, recent or changes to
___ Oily skin
___ Reactions to insect bites
___ Scars (locations): _____
___ Sebaceous cysts
___ Shingles (herpes zoster)
___ Skin tags
___ Swellings, lumps, nodules
___ Warts
___ Other: _____

Respiratory Health:
___ Allergies/hay fever
___ Asthma
___ Bronchitis
___ Colds, frequent
___ Cough (acute or chronic)
___ Emphysema
___ Hoarseness
___ Laryngitis
___ Nasal congestion
___ Phlegm, excessive production
___ Pleurisy
___ Pneumonia
___ Post-nasal drip
___ Shortness of breath
___ Snoring
___ Sore throat (acute or chronic)
___ Other: _____

Blood/Cardiovascular Health:
___ Anemia
___ Aneurysm
___ Angina/heart pain
___ Blood clots
___ Blood type: A O B AB *(circle)*
Positive or Negative type *(circle)*
___ Bruise easily
___ Chest pain or tightness
___ Cold hands and feet
___ Heart attack (history of)
___ Irregular heart beat
___ Heart disease
___ High cholesterol
___ Hypertension (high BP)
___ Hypotension (low BP)
___ Mitral valve prolapse
___ Murmur
___ Palpitations
___ Stroke (history of)
___ Varicose veins
___ Other: _____

Gastrointestinal Health:
___ Abdominal pain/cramps
___ Acid reflux/heartburn
___ Anorexia or Bulimia
___ Bloating & distension
___ Chronic use of laxatives
___ Colitis
___ Crohn's Disease
___ Constipation
___ Diarrhea
___ Esophageal spasms
___ Food allergies/sensitivities
___ Gallbladder disease
___ Gas/flatulence
___ Greasy, fatty food intolerance
___ Liver Disease (cirrhosis)
___ Liver, fatty
___ Hemorrhoids
___ Hiccoughs
___ Indigestion
___ Irritable Bowel Syndrome
___ Mouth taste (circle which apply): bitter; metallic; sticky; sweet
___ Nausea and/or vomiting
___ Pancreatitis
___ Parasites (history of)
___ Rectal itching
___ Stomach or duodenal ulcers
___ Stools (please circle any that apply): bloody; tarry; clay colored; mucus in stools; undigested food
Frequency of bowel movements per day:
_____
Do your bowel movements float or sink?
_____
___ Other: _____

Genito-Urinary Health:
___ Bed wetting (or history of)
___ Blood in the urine
___ Cystitis (bladder pain)
___ Dribbling after urination
___ Edema/leg swelling
___ Frequent urination
___ Incontinence
___ Kidney disease
___ Kidney stones
___ Nocturia (night-time urination)
___ Nephritis
___ Urethritis
___ Urinary tract infection history
How many times a day do you urinate? ___
What color is your urine?_____
Other: _____

Women's Reproductive History:
___ Age of 1st menses _____
___ Length of menses _____
___ Time between cycles _____
___ Heavy Bleeding
___ Light Bleeding
___ Menstrual blood color: _____
___ Clotting *(please describe the color of the clots)* _____
___ Lack of menstruation
___ Irregular menstruation
___ Painful menstruation
___ Pre-menstrual syndrome (breast tenderness, irritability, cramps, etc)
___ Bloating, water retention with period
# of abortions: _____
# of live births: _____
# of miscarriages: _____
___ Traumatic births
___ Use of birth control *(age & duration)*
_____
___ Postpartum weakness
___ Difficult conception/infertility

Women's Health (if applicable):
___ Abdominal lumps or masses
___ Breast cancer
___ Breast cysts or lumps
___ Breast tenderness
___ Endometreosis
___ Estrogen replacement use
___ Fibroids
___ Hot flashes
___ Menopause, age begun
___ Menopausal symptoms
___ Menstrual odor, strong
___ Nipple discharge
___ Pelvic/genital pain

___ Positive mammogram/pap smear
___ Severe menstrual cramps
___ Painful sex
___ Sex drive low
___ Sex drive excessive, difficulty control impulses
___ Vaginal discharge
___ Vaginal dryness
___ Vaginal odor
___ Venereal disease
___ Yeast infections
___ Other: _____

Men's Health (if applicable):
___ Erectile dysfunction
___ Impotence
___ Penile discharge
___ Premature ejaculation
___ Prostate enlargement/problems
___ Seminal incontinence
___ Sex drive diminished
___ Sex drive excessive
___ Venereal disease
___ Other: _____

Endocrine Health:
___ Addison' disease
___ Cushing's syndrome
___ Diabetes Type I
___ Diabetes Type II
___ Diabetes Insipidus
___ Fatigue (*time of day*): _____
___ Feeling hot or cold (*circle*)
___ Hypoglycemia
___ Hypothyroid
___ Hyperthyroid (Grave's Disease)
___ Insulin resistance
___ Lethargy
___ Pituitary disorders
___ Night sweats
___ Overweight How many lbs. overweight? _____
___ Weight gain, sudden
___ Weight loss
___ Other: _____

Neurological & Brain Health:
___ Concussion history
___ Difficulty concentrating
___ Drowsiness
___ Epilepsy
___ Lack of coordination and balance
___ Loss of muscle strength
___ Numbness & tingling in the limbs
___ Paralysis
___ Seizures
___ Tremors
___ Vertigo or dizziness

Musculo-skeletal Health & Pain:
___ Arm and elbow pain
___ Hand and wrist pain
___ Knee pain
___ Leg & calf pain
___ Gout
___ Hip pain and/or sciatica
___ Lower back pain
___ Neck, shoulder, upper back pain
___ Whole body pain
___ Facial pain/paralysis
___ Jaw tension/pain (TMJ syndrome)
___ Headaches *(location & sensation):*
_____
___ Migraines
___ Rheumatoid arthritis
___ Osteo-arthritis
___ Osteopenia (weakening bones)
___ Osteoporosis (bone loss)
___ Sciatica (down back of leg, side of leg, or both?) _____
___ Spinal curvature (scoliosis, lordosis, kyphosis, etc) _____
___ Tension in the back, shoulders, & neck related to stress response
___ Other: _____

Immune Health & Toxicity:
___ Candidiasis/ fungal infection
___ Chemical sensitivities
___ Chemotherapy or radiation treatment currently or history of
___ Chronic Fatigue Syndrome
___ Chronic infections: _____
___ Epstein Barr Virus
___ Hepatitis A, B, C, D, E
___ HIV/AIDS
___ Leukemia
___ Lyme disease
___ Lymph node swelling
___ Lymphoma
___ Mononucleosis
___ Parasites: _____
___ Reactions to food additives
___ Recent or past exposure to toxins, chemicals, pesticides, herbicides, mold, etc in the home or workplace
___ Live in home older than 30 years

Environmental Adaptation:
___ Changes in weather or barometric pressure aggravate symptoms or cause adverse reactions
___ Cold/damp environments aggravate symptoms or cause adverse reactions
___ Cold/dry environments aggravate symptoms or cause adverse reactions
___ Hot/humid environments aggravate symptoms or cause adverse reactions
___ Hot/dry environments aggravate symptoms or cause adverse reactions
___ Seasonal changes aggravate symptoms or cause adverse reactions

Lifestyle: *(Please indicate amount)*
___ Alcohol consumption: _____
___ Caffeinated and carbonated beverages:
_____
___ Coffee or black tea:
___ Exercise: _____
___ Recreational drugs (please list):
_____
___ Tobacco consumption _____
___ Water consumption:_____
How often do you eat? _____
Do you suffer from insomnia? _____
Is it more difficult to get to sleep, stay asleep, or both? _____
How many hours do you sleep per night?_____
____
If you sleep for 8 hours are you rested or still wake tired? _____

Psychological/Emotional Health:
___ Anxiety
___ Depression
___Worry, over-concern
___ Anger, frustration. irritability
___ Fear, paranoia
___ Grief, sadness
___ Bi-polar
___ Schizophrenia
___ ADD or ADHD
___ Addictions. Please list: _____
_____
___ Attempted suicide
___ Suicidal thoughts
___ Panic attacks
___ PTSD
___ Other: _____

I certify the above information is true and correct to the best of my knowledge.

Patient Name & Signature:
_____

_____

Date: _____

Student Name & Signature:
_____

_____

Supervisor Name & Signature:
_____

_____

Date: _____