Lifegate Acupuncture

Patient Information

Confidential

Welcome to Lifegate Acupuncture & Herbal Clinic

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. Lifegate Acupuncture Clinic *considers this information privileged physician/patient communication and will hold it in confidence.*

NAME (LAST, FIRST, MIDDLE)	DATE

AGE	DATE OF BIRTH	SEX	MARITAL STATUS
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PHONE (HOME)	PHONE (CELL)	PHONE (WORK)

HOME ADDRESS		
CITY	STATE	ZIP

OCCUPATION	EMAIL ADDRESS

EMPLOYED BY		
EMPLOYERS ADDRESS		
CITY	STATE	ZIP

REFFERED BY

SPOUSE'S NAME

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE

ADDITIONAL INFORMATION/NOTES

I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Lifegate Acupuncture Clinic is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

SIGNATURE _____ DATE _____

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Medical History

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NAME (LAST, FIRST, MIDDLE)	DATE

MAJOR COMPLAINT/HEALTH PROBLEM

HOW DID THIS CONDITION DEVELOP?

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? ☐ Yes ☐ No	IF YES, WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?

WHAT WERE THE RESULTS OF THE TREATMENT?

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

MEDICATION	STRENGTH	HOW MANY PER DAY	FOW HOW LONG

LIST ANY MAJOR SURGERIES YOU HAVE HAD:

DATE	PROBLEM/SURGERY

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ AIDS
- ☐ Cancer
- ☐ Connective Tissue Disease
- ☐ Diabetes
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Stones
- ☐ Rheumatic Fever
- ☐ Ruptured Appendix
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Venereal Disease

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Health History

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NAME (LAST, FIRST, MIDDLE)	DATE

Please check any symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Low energy
- ☐ Dizziness
- ☐ Allergies
- ☐ Fatigue
- ☐ Fevers
- ☐ Excess thirst
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweat spontaneously
- ☐ Night sweating
- ☐ Lack of sweating
- ☐ Weight loss
- ☐ Weight gain
- ☐ Aversion to heat
- ☐ Aversion to cold

Head & Neck
- ☐ Blurred vision
- ☐ Heaviness in the head
- ☐ Headache
- ☐ Phlegm in throat
- ☐ Cataract
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Eye pain/strain
- ☐ Corrected vision
- ☐ Nasal obstruction
- ☐ Nasal discharge
- ☐ Loss of sense of smell
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Recurrent sore throat
- ☐ Red/inflamed eye
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sores on lips
- ☐ Sores on tongue
- ☐ Taste change
- ☐ Teeth problems
- ☐ Vision – see halos

Respiratory
- ☐ Asthma
- ☐ Hay fever
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Recurrent bronchitis
- ☐ Phlegm production
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Hypochondriac pain
- ☐ Distention in chest or hypochondrium

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Bloody stools
- ☐ Black stools
- ☐ Difficulty swallowing
- ☐ Poor appetite
- ☐ Heartburn/reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Poor appetite
- ☐ Stomachache
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood

Diet/Lifestyle
- ☐ Vegetarian
- ☐ Healthy diet
- ☐ Eat much fried foods
- ☐ Eat much meat
- ☐ Smoke cigarettes
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Use drugs
- ☐ Eat a lot of sweets
- ☐ Take melatonin
- ☐ Take steroids
- ☐ Exercise regularly
- ☐ Exercise excessively

Weight
- ☐ Underweight
- ☐ Normal for height
- ☐ Overweight
- ☐ Very overweight

Genitourinary
- ☐ Dilute urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Frequent urination
- ☐ Poor bladder control
- ☐ Urgency to urinate

Musculoskeletal

Pain, weakness, numbness in:
- ☐ Arms
- ☐ Feet
- ☐ Hands
- ☐ Joints
- ☐ Legs
- ☐ Hips
- ☐ Neck
- ☐ Shoulders
- ☐ Pain all over
- ☐ Cold limbs
- ☐ Knee problems
- ☐ Low back pain
- ☐ All over weakness
- ☐ Lack of strength
- ☐ Broken bones

Skin
- ☐ Thick skin
- ☐ Thin skin
- ☐ Broken blood vessels
- ☐ Blood not clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Dark circles around eyes
- ☐ Bags under eyes
- ☐ Lumps in groin
- ☐ Lumps underarm
- ☐ Dry skin
- ☐ Acne
- ☐ Brittle nails
- ☐ Premature gray hair
- ☐ Dry, brittle hair
- ☐ Hair falling out

Neurologic
- ☐ Fainting
- ☐ Convulsions
- ☐ Handwriting change
- ☐ Paralysis
- ☐ Stroke
- ☐ Seizures
- ☐ Tremor
- ☐ Recent clumsiness
- ☐ Drowsiness
- ☐ Vertigo

Emotional
- ☐ Insomnia
- ☐ Irritability
- ☐ Often feel angry
- ☐ Troubling dreams
- ☐ Cry uncontrollably
- ☐ Feel sad a lot
- ☐ Forgetful
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Much fear
- ☐ Unrestrained joy
- ☐ Terrors
- ☐ Difficulty expressing emotions

Men Only
- ☐ Genital pain
- ☐ Impotence
- ☐ Genital sores
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Nocturnal emission
- ☐ Low sexual energy

Women Only
- ☐ Abnormal pap smear
- ☐ Bleed between periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ <25 day cycle
- ☐ >35 day cycle
- ☐ Endometriosis
- ☐ Painful periods
- ☐ Premenstrual tension
- ☐ Breast lumps
- ☐ Contraceptives
- ☐ Sores on genitalia
- ☐ Low sexual energy
- ☐ Vaginal discharges
- ☐ Menopausal
- ☐ Uterine prolapse
- ☐ Facial hair
- ☐ Loss of head hair
- ☐ May be pregnant

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Women's Fertility History

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NAME (LAST, FIRST, MIDDLE)	DATE

Age at which menses began _____

Are your periods painful? ☐ Yes ☐ No

How many days does the pain last?_____

How many days do you normally bleed?_____

How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy

What color is the blood? ☐ Light red ☐ Red ☐ Dark red ☐ Purple ☐ Brown ☐ Black

Is there clotting? ☐ Yes ☐ No

Do you have premenstrual tension? ☐ Yes ☐ No

Does your face break out before or during your period? ☐ Yes ☐ No

Do your breasts become tender premenstrually? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Are your menstrual cycles spaced irregularly? ☐ Yes ☐ No

How many days are there from from one period to the next?_____

Date of last menstrual period_____

	Number	Years
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many abortions have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been performed?	_____	_____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

Do you get yeast infections regularly? ☐ Yes ☐ No

Have you ever been diagnosed with a chlamydial infection? ☐ Yes ☐ No

Do you have chronic vaginal discharge? ☐ Yes ☐ No

Do you have any sores on your genitalia? ☐ Yes ☐ No

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No

Were you treated for it? ☐ Yes ☐ No

How_____

_____

Date of last Pap smear_____

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No

Have you been diagnosed with pelvic adhesions? ☐ Yes ☐ No

Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	**Reason**	**How long**

Have your cycles changed since they began? ☐ Yes ☐ No

How? _____

Do you ovulate on your own? ☐ Yes ☐ No

On what day of your cycle?_____

Do your breasts get tender at/during ovulation? ☐ Yes ☐ No

Do you get premenstral low back pain? Yes No

Do your bowel movements become loose at the beginning of you period? ☐ Yes ☐ No

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Women's Fertility History *Continued*

Confidential

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when and where?_____

By whom?_____

What types?_____

Have you taken medication to help you ovulate? ☐ Yes ☐ No

When _____ How long?_____

Have your fallopian tubes been evaluated medically? ☐ Yes ☐ No

What were the results?_____

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormone laboratory tests performed? ☐ Yes ☐ No

What were the results?_____

_____

Do you have a single partner
with whom you have been trying to conceive? ☐ Yes ☐ No

How long have you been married or living together?_____

Has he had a fertility workup? ☐ Yes ☐ No

What were the results?_____

Is your partner supportive of your wish to conceive? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No

When _____ How long?_____

Have you ever had an IUD? ☐ Yes ☐ No

When _____ How long?_____

Have you ever taken DepoProvera? ☐ Yes ☐ No

When _____ How long?_____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ☐ Yes ☐ No

What was it?_____

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you douche regularly? ☐ Yes ☐ No

With what?_____

Do you use vaginal lubricants? ☐ Yes ☐ No

Are you more than 20% over your ideal body weight? ☐ Yes ☐ No

Are you more than 20% below your ideal body weight? ☐ Yes ☐ No

Do you have a stressful occupation? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you have excessive facial hair? ☐ Yes ☐ No

Do you have excessively oily skin? ☐ Yes ☐ No

Have you experienced excessive loss of head hair? ☐ Yes ☐ No

Have you noticed discharge from your nipples? ☐ Yes ☐ No

Was your mother exposed to
diethylstilbestrol (DES) when she was pregnant with you? ☐ Yes ☐ No

Have you been exposed to any
known environmental toxins or hormones? ☐ Yes ☐ No

Are you presently taking steroids? ☐ Yes ☐ No

COMMENTS/NOTES