

**BINA JANGDA ACUPUNCTURE AND INTEGRATIVE MEDICINE**

Patient Information

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Street Address Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Office ( ) \_\_\_\_\_

Other Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

single     married     divorced     widowed     domestic partnership     other

Referred by \_\_\_\_\_

Emergency Contact Relationship \_\_\_\_\_

Emergency Contact Phone # home ( ) \_\_\_\_\_ Office or Cell \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_

Employment - Please check all that apply

full-time     part-time     self-employed     student     unemployed     retired

Occupation Number of hours of work/study per week \_\_\_\_\_

Employer's Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Billing and Insurance

Health Insurance Information

Our billing department can check your eligibility. We will bill your insurance for you. Any amount not paid by your insurance is your responsibility. By signing below, you agree to assume all responsibility for any portion not covered by your insurance.

Signature: \_\_\_\_\_

Primary Insurance Phone ( ) \_\_\_\_\_

Primary Insurance Address \_\_\_\_\_

Policy Holder's Name Relationship \_\_\_\_\_

Policy # / ID # Group # \_\_\_\_\_

# BINA JANGDA ACUPUNCTURE AND INTEGRATIVE MEDICINE

## Confidentiality

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

## Health History

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Have you had acupuncture treatment before? If so, for what reason? \_\_\_\_\_  
\_\_\_\_\_

### Pain

l, r, b = left, right, or both sides

past current	past current	past current	past current
___ ___ head	___ ___ forearm l r b	___ ___ upper back	___ ___ shin l r b
___ ___ jaw	___ ___ wrist l r b	___ ___ mid-back	___ ___ ankle l r b
___ ___ neck	___ ___ hand l r b	___ ___ low back	___ ___ foot l r b
___ ___ throat	___ ___ fingers l r b	___ ___ hip l r b	___ ___ heel l r b
___ ___ shoulder l r b	___ ___ chest	___ ___ thigh l r b	___ ___ toes l r b
___ ___ upper arm l r b	___ ___ rib / flank	___ ___ knee l r b	
___ ___ elbow l r b	___ ___ abdomen	___ ___ calf l r b	

other current related symptoms \_\_\_\_\_  
\_\_\_\_\_

### ST

**past current**  
\_\_\_ \_\_\_ nausea / vomiting  
\_\_\_ \_\_\_ belching  
\_\_\_ \_\_\_ heartburn  
\_\_\_ \_\_\_ bad breath  
\_\_\_ \_\_\_ bleeding gums  
\_\_\_ \_\_\_ ulcers  
\_\_\_ \_\_\_ excessive appetite  
\_\_\_ \_\_\_ change in appetite  
\_\_\_ \_\_\_ nose bleeds  
\_\_\_ \_\_\_ difficulty swallowing  
\_\_\_ \_\_\_ recurring sore throat  
\_\_\_ \_\_\_ laryngitis / hoarse voice

### Sp

**past current**  
\_\_\_ \_\_\_ gas  
\_\_\_ \_\_\_ abdominal bloating  
\_\_\_ \_\_\_ abdominal pain  
\_\_\_ \_\_\_ decreased appetite  
\_\_\_ \_\_\_ indigestion  
\_\_\_ \_\_\_ low energy / fatigue  
\_\_\_ \_\_\_ crave sweets  
\_\_\_ \_\_\_ decreased sense of taste / smell  
\_\_\_ \_\_\_ sweet taste in mouth  
\_\_\_ \_\_\_ often feel pensive / thoughtful  
\_\_\_ \_\_\_ edema

**past current**  
\_\_\_ \_\_\_ diarrhea  
\_\_\_ \_\_\_ constipation  
\_\_\_ \_\_\_ blood in stools / black  
\_\_\_ \_\_\_ pus in stools  
\_\_\_ \_\_\_ hemorrhoids  
\_\_\_ \_\_\_ anal fissures  
\_\_\_ \_\_\_ rectal pain

other current related symptoms \_\_\_\_\_  
\_\_\_\_\_

# BINA JANGDA ACUPUNCTURE AND INTEGRATIVE MEDICINE

## Lu

### past current

- frequent colds
- sinus infection
- cough
- cough with blood
- production of phlegm
- hay fever or allergies

### past current

- asthma
- bronchitis
- pneumonia
- COPD
- acne
- rashes, hives, eczema or psoriasis

### past current

- often feel sad
- crave pungent foods
- dry skin
- itching

other current related symptoms \_\_\_\_\_

## K

### past current

- frequent urination
- urgency to urinate
- pain on urination
- urine/bowel incontinence
- weak urine stream
- blood in urine
- kidney stones
- low back pain
- sore / weak knees
- crave salty foods
- often feel afraid

### past current

- frequent urinary tract infections
- frequent vaginal infections
- pelvic inflammatory disease
- abnormal PAP smear
- irregular periods
- premenstrual syndrome
- painful menstrual periods
- abnormal bleeding
- menopause symptoms
- breast lumps
- ear infections

### past current

- impotence
- premature ejaculation
- testicular lumps
- prostatitis
- genital itching /pain
- genital lesions/discharge
- decreased libido
- ear ringing –low pitch
- ear ringing –high pitch
- decreased hearing

Total Pregnancies \_\_\_\_\_ Living \_\_\_\_\_ Ectopic \_\_\_\_\_ Miscarriages \_\_\_\_\_

Induced Abortions \_\_\_\_\_

other current related symptoms \_\_\_\_\_

## LV.

### past current )

- dry eyes
- red eyes
- eye inflammation
- blurred vision
- poor night vision
- irritability
- treated for emotional / psychological problems
- cataracts
- crave sour foods
- tendonitis

## X

### past current

- insomnia
- excessive / vivid dreams
- grinding teeth
- depression
- anxiety / stress
- floaters (spots in the visual field)
- numbness or tingling of limbs
- poor concentration
- indecisiveness
- often feel angry
- gallstones

### past current

- migraine
- dizziness
- fainting
- seizures
- localized weakness
- visual changes
- glasses / contact lenses
- tremors
- paralysis
- aversion to wind

other current related symptoms \_\_\_\_\_

**BINA JANGDA ACUPUNCTURE AND INTEGRATIVE MEDICINE**

**Ht**

**past current**

- high blood pressure
- low blood pressure
- palpitations
- irregular heart beat

**past current**

- chest pain or pressure
- jaw, neck, shoulder or arm pain
- nausea
- swollen hands or feet

**past current**

- blood clotting disorders
- phlebitis
- poor memory
- crave bitter foods

other current related symptoms \_\_\_\_\_

**YM**

**past current**

- fevers
- frequent or strong thirst
- tend to feel warmer than others
- night sweats
- sweat easily
- prefer cold food and drink

**past current**

- chills
- hands / feet
- tend to feel colder than others
- cold sweats
- prefer warm food and drink

**past current**

- headache
- neck stiffness
- concussion
- enlarged lymph

**tumors or lumps**

**past current**

- HIV
- TB
- chicken pox
- meningitis
- hepatitis

**past current**

- gonorrhea
- chlamydia
- syphilis
- genital warts
- herpes oral / genitals

**past current**

- SARS
- west Nile

other current related symptoms \_\_\_\_\_

**Recent Tests and indicate results**

---

cholesterol \_\_\_\_\_ blood pressure \_\_\_\_\_ mammography \_\_\_\_\_ prostate

blood work \_\_\_\_\_ STD Check \_\_\_\_\_

other tests and results \_\_\_\_\_

## ***BINA JANGDA ACUPUNCTURE AND INTEGRATIVE MEDICINE***

**FAMILY HISTORY** Complete for each family member, placing an X in the appropriate box

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder / Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Drug / Alcohol Use or Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression / Mental Illness							
Suicide Attempt							
Age at Death							

**Major Hospitalizations – Please list any hospitalization or surgeries you have undergone**

Year	Operation or Illness	Name of Hospital	City and State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Medicines, Herbs, Supplements – Please check any that you are currently taking**

<input type="checkbox"/> aspirin	<input type="checkbox"/> antacids	<input type="checkbox"/> blood thinners	<input type="checkbox"/> sleeping pills
<input type="checkbox"/> ibuprofen	<input type="checkbox"/> fiber / laxatives	<input type="checkbox"/> blood pressure pills	<input type="checkbox"/> tranquilizers
<input type="checkbox"/> acetaminophen (Tylenol)	<input type="checkbox"/> allergy medication	<input type="checkbox"/> diet pills	<input type="checkbox"/> insulin
<input type="checkbox"/> oral contraceptives		<input type="checkbox"/> antidepressants	

other, please list \_\_\_\_\_  
 \_\_\_\_\_

**BINA JANGDA ACUPUNCTURE AND INTEGRATIVE MEDICINE**

**Western Drugs**

**Herbs**

**Vitamins and Supplements**

---

---

---

**Medication Allergies** \_\_\_\_\_

**Food Allergies** \_\_\_\_\_

**Habits – Please check any habits which apply to you now or in the past**

Coffee \_\_ yes \_\_ no                    # per day \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_  
Tobacco \_\_ yes \_\_ no                    # per day \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_  
Marijuana \_\_ yes \_\_ no                    # per day \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_  
Alcohol \_\_ yes \_\_ no                    # per day \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_  
Crack/Cocaine \_\_ yes \_\_ no                    # per day \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_  
Heroin \_\_ yes \_\_ no                    # per day \_\_\_\_\_ age started \_\_\_\_\_ age quit \_\_\_\_\_

**Please describe any restricted diet you follow(ed) now or in the past** \_\_\_\_\_

---

**Please describe you typical daily diet**

Breakfast \_\_\_\_\_ Morning Snack \_\_\_\_\_  
Lunch \_\_\_\_\_ Afternoon Snack \_\_\_\_\_  
Dinner \_\_\_\_\_ Evening Snack \_\_\_\_\_

***BINA JANGDA ACUPUNCTURE AND INTEGRATIVE MEDICINE***

Please list your health concerns in order of importance –

Please describe any regular program of exercise –

Do you have a religious or spiritual practice? If so, please describe –

What are the top priorities in your life?

What are your goals for your health?

Please provide any additional information about yourself or your condition not covered by the above questions.