Lily Choi Natural Healing
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lilychoinaturalhealing.com

Name: Last_____ First_____ Middle_____
Date_____ DOB _____ /____/_____ Gender F ____M _____ Email _____ Address
_____

City _____State_____ Zip_____ Telephone: Home (_____) _____-_____

Cell (_____) _____-_____ Marital Status: _____

Education (Highest grade or degree achieved) _____

How did you hear about our clinic? _____ Have you been treated by Acupuncture or Oriental medicine before? _____

Name of your physician: _____ Tel: (_____) _____ - _____ Address of your physician: _____ City _____ State _____ Zip Code_____

In an Emergency Notify |

Name _____

Phone (_____) _____-_____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

1.Main problem you would like us to help you with:

_____

2. How long ago did this problem begin?

_____

3. Have you been given a diagnosis for this problem? If so, what?

_____

4. What kinds of treatment have you tried?

_____

5. Are you currently receiving treatment for your problem? _____
If so, please describe: _____

_____

6. Does anything improve your problem?

_____

PAST MEDICAL HISTORY

Illnesses: _____

Surgeries: _____

Significant Trauma (Auto accidents, falls, etc.)

Do you have, or have you ever had, any Infectious Diseases? (Circle One) Yes / No
If so, please describe

Medicines (prescription and over-the-counter drugs, recreational drugs, vitamins, herbs, etc. taken within the last three months):

Allergies:

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side

Father's Side

Siblings

If any of the above is deceased, what was the cause?

PERSONAL HISTORY

Birth History (Prolonged labor, forceps, delivery, etc.):

Childhood health:

Location of upbringing (Geographically prone to certain diseases, habits, etc.):

Current Emotional Health:

Current Quality of Life: _____

Current Relationship/Quality: _____
Current Predominant Emotion: _____ Stress Level: _____ Have you had any unusual stresses recently? _____
Favorite time of year: _____ Worst _____
Hobbies & Recreational Habits

_____
Do you have a regular exercise program? Yes / No If so, please describe:

_____
Have you traveled abroad in the past year? Yes / No Where?

_____
If applicable, please describe smoking or alcohol intake:

_____

NEUROPSYCHOLOGICAL (Circle all that apply)

Seizures	Concussion	Areas of Numbness	Fainting
Disorientation	Anxiety	Dizziness	Depression
Poor Memory	Headaches	Migraines	Loss of Balance
Easily Stressed	Lack of Coordination	Easily Angered	Mania

Have you ever been treated for emotional problem?

_____
Have you ever considered or attempted suicide?

_____
Any other neurological or psychological problems?

_____
Any nervous habits?

_____

PREGNANCY

___ Number of Pregnancies ___ Number of Births ___ Miscarriages ___Abortions

(Circle all that apply) Difficult Births Breast Lumps Clots

GYNECOLOGY

___Age at First Menses ___Period between Menses ___Duration of Menses

(Circle all that apply)

Unusual Character Heavy Light Irregular Periods Painful Periods

Birth Control? Y / N What type? _____

How long? _____ First Date of Last Menstrual Cycle _____/_____/_____

Date of Last Pap Smear _____/ _____/ _____ Do you experience changes in Body and/or Psyche prior to menstruation? _____

PLEASE CIRCLE ALL THAT APPLY (EXPERIENCED IN THE LAST THREE (3) MONTHS)

GENERAL

Fevers Chills Fatigue Tremors Change in Appetite Seizures Night Sweats

Peculiar tastes or smells Sudden Energy Drops/What time of Day? _____ Poor Sleep/Insomnia

Strong thirst for Hot or Cold drinks? Dream Disturbed Sleep Poor Balance Joint Pain

Headaches Weight Gain Cold Sweats Day Sweating Mania Poor Appetite

Depression Bleeding or Bruises Weight Loss Localized Weakness Emotional Changes

CARDIOVASCULAR

Swelling of Hands Cold Hands/Feet High blood pressure Blood Clots Fainting

Difficulty Breathing Phlebitis Low Blood Pressure Palpitations Swelling of Feet

Irregular heartbeat Chest pain Dizziness

RESPIRATORY

Cough Asthma Difficulty Breathing Easily Winded w/ Exertion when laying down

Coughing Blood Shortness of Breath Bronchitis Production of phlegm / Color? _____

GASTROINTESTINAL

Nausea Vomiting Indigestion Abdominal Pain/ Cramps Belching Ulcers Hernia

Bad Breath Hemorrhoids Digestive Disorder Parasites Diarrhea Constipation Blood in Stool

GENTIO-URINARY

Pain on Urination Urgent Urination Blood in Urine Impotency/ Infertility Genital Sores

Frequent Urination Unable to Hold Urine Decrease in Urine Kidney Sores

Waking up to Urinate / How often? _____

MUSCULOSKELETAL

Muscular Weakness Muscle Cramps Injuries or Falls General Aches Arthritis

Muscular Atrophy Joint Instability Recent Sprains Pain w/ Deep Breaths Spasms

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Please use the scale below to tell us how intense your pain is, place a circle through the number that best describes the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10

No pain **Most intense pain**

Are there any other internal organ or systemic dysfunctions that we should be aware of?

_____

Are there any other problems you would like to discuss?

_____

_____

Consent for Acupuncture

I, _____, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

_____ _____/_____/_____

Patients signature (Parent or Guardian's signature if under 18) **Date**

Cancellation Policy:

All fees for services are due at the time of each appointment unless you purchased special treatment packages (in which case you had prepaid for several treatments during your first visit). I accept cash, check, or credit card (VISA, MASTER CARD, AMEX).

Your appointment time is reserved especially for you. I encourage that you keep the appointment so that we can continue working towards your optimum health. If, however, you cannot make the appointment time, or need to reschedule, please do so within 24 hours before your appointment. You can do so through the online scheduling system, or you can call, text, or email me.

The fee for late cancellation (less than 24 hours) is the full amount of your visit, unless you reschedule for another time within a week of your previous appointment. I appreciate your understanding and cooperation.

_____ _____/_____/_____

Patients signature (Parent or Guardian's signature if under 18) **Date**

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Food Diary

Typical Breakfast Choices:

_____

_____

_____

Typical After Breakfast Snack Choices:

_____

_____

_____

Typical Lunch Choices:

_____

_____

_____

Typical After Lunch Snack Choices:

_____

_____

_____

Typical Dinner Choices:

_____
_____
_____

Typical After Dinner Snack Choices:

_____
_____
_____

Refreshments: (Jot down all the different refreshments you have throughout the day.)

_____
_____
_____

List all the Vitamins & Supplements previously or currently taking:

_____
_____
_____