Yang Acupuncture Clinic

778 B Street Suite B, Hayward, CA 94541

PATIENT HEALTH INFORMATION

PRESENT HISTORY

Please list your reasons for seeking treatment and their history in order of importance:

	Date of Onset	Chief Complaints
1.		
2.		
3.		

Do you experience pain in any of the following (check boxes)?

☐ Headache	☐ Upper Back	☐ Arm (R/L)	☐ Leg (R/L)
☐ Neck	☐ Lower Back	☐ Hand (R/L)	☐ Knee (R/L)
☐ Shoulder (R/L)	☐ Hip (R/L)	☐ Abdomen	☐ Foot (R/L)

Have You Had X-rays Taken in the Last 3 Years? ☐ Yes ☐ No

Please list your most recent hospitalization and/or surgeries below:

	Date	Doctor	Medical Condition	Address
1.				
2.				

Please list any chronic diseases you have had (past or present) below:

☐ Sexually Transmitted Disease	☐ Cancer	☐ Hepatitis
☐ Epstein-Barr ☐ Syphilis	☐ HIV OR AIDS	

Please list Medication, Drugs, Herbs, and/or Vitamins you are currently taking:

Do You Currently Use a pacemaker or any Other Internal Electronic Device? ☐ Yes ☐ No

If Yes, for what Conditions(s)? _____

Please list your known allergies: _____

Do You have any implant/metal in your body? ☐ Yes ☐ No

If Yes, for what Conditions(s)? _____

Where? _____

How did the condition(s) for which you are seeking treatment first present themselves?

Please specify location (work, accident, or others), situation, and approximate date below

☐ At Work ☐ Acccident (Car) ☐ Others

_____

_____

PERSONAL HISTORY

Men:

Please check the box next to any of the following symptoms that you currently experience:

☐ Premature Ejaculation ☐ Nocturnal Emission ☐ Impotence
☐ Prostatitis or Enlargement ☐ Others: _____

_____

Women:

Number of days between periods: _____

Average duration of periods: _____

Do you use birth control? ☐ Yes ☐ No

If so, what type and for how long? _____

Number of children: _____ Number of abortions: _____

Date of last abortion: _____

Please check the box next to any of the following symptoms that you currently experience:

☐ Vaginal Infection ☐ Pelvic Infection ☐ Ovarian Cyst(s)
☐ PMS ☐ Menstrual Dysfunction ☐ Breast Lumps
☐ Cervicocolpitis ☐ Hysteromyoma ☐ Ectopic Pregnancy

FAMILY HISTORY

Do you have relatives who have experienced any of the following medical conditions?

- ☐ Diabetes
- ☐ Mental Disorder
- ☐ Heart Disease
- ☐ Stroke
- ☐ Hypertension
- ☐ Weight Problems
- ☐ Cancer
- ☐ Hypotension

PAST HISTORY

Please mark the box next to any symptom you have experienced in the past three years:

Wood (Liver)

- ☐ Headache
- ☐ Migraine
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Poor Eye sight
- ☐ Tightness in Jaw
- ☐ Nervousness
- ☐ Spasms
- ☐ Irritability
- ☐ Tightness in Chest
- ☐ Tendency to Sighing
- ☐ Insomnia
- ☐ Flank Pain
- ☐ Tight Neck
- ☐ Tight Shoulders

Fire (Heart)

- ☐ Thirst
- ☐ Gum problems
- ☐ Swollen Lymph Nodes
- ☐ Dry Scalp
- ☐ Red Face
- ☐ Malar Flush
- ☐ Aversion to Heat
- ☐ Hot Palms/Soles
- ☐ Night Sweats
- ☐ Tidal Fever
- ☐ Itchy, Burning Skin
- ☐ Constipation
- ☐ Dark Urine
- ☐ Nose Bleeding
- ☐ Pain Around Ribs

Water (Kidney)

- ☐ Lower Back Pain
- ☐ Weak Legs/Knees
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Infertility/Sterility
- ☐ Low Sexual Desire
- ☐ Hair Premature Graying
- ☐ Hearing Loss
- ☐ Tinnitus (Ear Ringing)
- ☐ Dark Circles Under Eye
- ☐ Edema
- ☐ Loose teeth
- ☐ Aversion to Cold

Metal (Lung)

- ☐ Cough
- ☐ Clear Mucus
- ☐ Yellow Mucus
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Sinus Congestion
- ☐ Stuffy Nose
- ☐ Hay Fever
- ☐ Nasal Infection
- ☐ Easily Catch Colds
- ☐ Bronchitis
- ☐ Smoking Problem
- ☐ Anemia

Earth (Spleen)

- ☐ Weak Appetite
- ☐ Strong Appetite
- ☐ Belching
- ☐ Indigestion
- ☐ Gas
- ☐ Diarrhea
- ☐ Food Allergies
- ☐ Heartburn
- ☐ Bloating
- ☐ Low Body Weight
- ☐ Overweight
- ☐ Prolapsed Organ
- ☐ Hemorrhoids
- ☐ Fatigue

Others

- ☐ Herpes Simplex
- ☐ Nerve Pain
- ☐ Sciatica
- ☐ Slipped Disc
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Gential Burning
- ☐ Anal Fissures
- ☐ Uri. Tract Infection
- ☐ Arthritis
- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Attack
- ☐ Diabetes