Qualicare Natural Health Clinic
Acupuncture • Chinese Herbal Medicine
P.O. Box 7342 · Bellevue, WA 98008-1342

Xiapin Song MS, LAc.
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CONFIDENTIAL PATIENT INFORMATION

1	Patient Name:	12	Family Physician Name: Dr. Contact Phone:
2	Gender: Marital Status: Date of Birth: (MM/DD/YYYY) / /	13	Hospital / Clinic Name:
3	Phone: (H): ( ) Phone (C): ( )	14	Hospital / Clinic Address:
4	E-Mail: SSN: (For insurance purpose) – –	15	City: State: Zip:
5	Address:	16	Referred By your Dr? Referral #: Yes: ☐ No: ☐
6	City: State: Zip:	17	In Case of Emergency, Contact Name:
7	Employer Name: Office Phone: ( )	18	Relationship: Phone #: ( )
8	Primary Insurance name:	19	Have you been treated by acupuncture before?
9	Member ID#. Group #:	20	When & Where? (If Yes)
10	Secondary Insurance name (if you have):	21	How do you hear about our clinic?
11	2nd Insurance Member ID#. 2nd Insurance Group #:	22	Referred By whom?

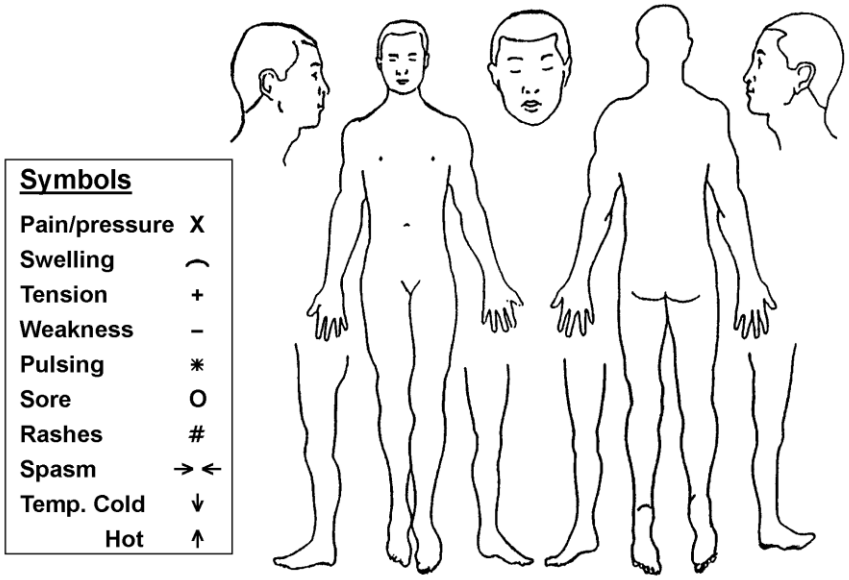
Main problem(s) you would like us to help with

1)

2)

3)

Indicate painful or distressed areas:



Please over

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When did this problem begin (be specific)?
To what extent does this problem interfere with your daily activity (work, sleep, and sex)?
What do you believe is wrong with you?
Have you been given a diagnosis for this problem? If so, What?
Name of last doctor consulted:
List medications currently taking, with dosage:

Past Medical History *(Please include date)*

Serious Illness:		
Surgeries:		
Major Accidents:		
Birth History (prolonged labor, forceps delivery, etc.):		
Hospitalizations:		
Allergies: To medications:	Foods:	
Chemicals:	Inhalants:	
Family Medical History:		
Occupational stress (chemical, physical, psychological, etc.):		
Do you have a regular exercise program?	If yes, Please describe:	
Have you ever been on a restricted diet?	What kind?	
Please describe your average daily diet:		
Morning:	Afternoon:	Evening:
How many packs of cigarettes do you smoke a day?		
How much coffee, tea, or cola do you drink per week?		
How much alcohol do you drink per week?		
Please describe any use of drugs for non-medical purposes:		

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Please check if you have had *(in the last three months)*

General:

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot drinks)
- ☐ Sudden energy drops (What time of day)?
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain

Skin and Hair:

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Ulceration
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Any other hair or skin problems?

Head, Eyes, Ears, Nose and Throat:

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐

Headaches? (where and when)

Any other head or neck problems?

Musculoskeletal:

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand / wrist pains
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot / ankle pain
- ☐ Hip pain

Any other joint or bone problems?

Gastrointestinal:

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids

Any other problems with your stomach or intestines?

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Cardiovascular:

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain
☐ Irregular heartbeat ☐ Dizziness ☐ Fainting
☐ Cold hands or feet ☐ Swelling of hands ☐ Swelling of feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty in breathing

Any other heart or blood vessel problems?

Respiratory:

☐ Cough ☐ Coughing blood ☐ Asthma
☐ Bronchitis ☐ Pneumonia ☐ Pain with a deep breath
☐ Difficulty in breathing when lying down
☐ Production of phlegm ? what color?

Any other lung problems?

Genito-Urinary:

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine
☐ Urgency to urinate ☐ Unable to hold urine ☐ Kidney stones
☐ Decrease in flow ☐ Impotency ☐ Sores on genitals

Do you wake up to urinate? ☐ No. ☐ Yes. How often?

Any particular color to your urine?

Any other problems with your genital or urinary system?

Pregnancy and Gynecology:

☐ Number of pregnancies ☐ Number of births ☐ Premature births
☐ Miscarriages ☐ Abortions ☐ Age at first menses
☐ Period between menses ☐ Duration ☐ First date of last menses
☐ Unusual character (heavy or light) ☐ Irregular periods
☐ Painful periods ☐ Clots ☐ Last PAP
☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps
☐ Changes in body / psyche prior to menstruation

Do you practice birth control? ☐ No. ☐ Yes, What type and for how long?

Neuropsychological:

☐ Seizures ☐ Dizziness ☐ Loss of Balance
☐ Areas of numbness ☐ Lack of coordination ☐ Poor memory
☐ Concussion ☐ Depression ☐ Anxiety
☐ Bad temper ☐ Easily susceptible to stress ☐

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Comments:

Please tell us of any other problems you would like to discuss:

Signature of Patient: _____ **Date:** _____

Please Over