

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so. If you have a preferred method of our contacting you please circle the e-mail address or phone number of your preferred choice; we will always try that method first.

Name _____

Address _____

City _____ State _____ Zip _____

e-mail address _____

Phones:

Home _____ Cell _____

Work _____ Extension _____

Gender (circle one) Male/Female

SS# _____ Age _____ Date of Birth _____

Employer _____ Occupation _____

Marital Status (circle one) Single/Married/ Divorced

Name of Spouse _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell/Work Phone _____

How did you find out about us?

- Referred by (circle one) Friend/Relative/Professional
Name _____
- Other _____

Primary Care Physician:

Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Signature of Patient (or Responsible Party if Patient is a Minor)

Date

Printed Name of Signer

Relationship to Patient

215 S Northwest Hwy Suite 102B
Barrington IL 60010
Phone 847-382-1884

We are located on the east side of Northwest Highway (Route 14)
south of Main St (Lake Cook Rd)

Patient Name _____

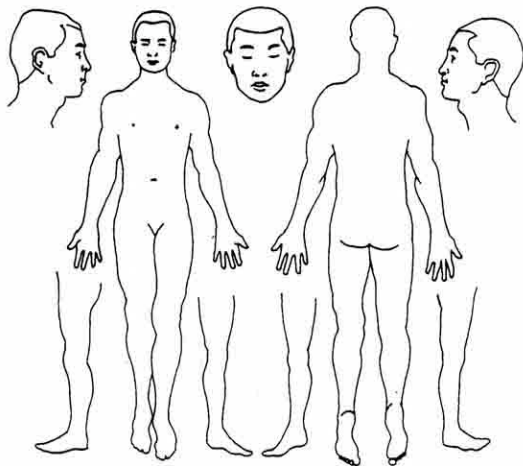
Date _____

Reason for visiting Barrington Acupuncture Clinic _____

Are you experiencing pain/discomfort in any area of your body (circle one)? Yes/No

If yes, using the models below to indicate the location of discomfort by using the symbol that best describes the feeling:

- XXX Sharp/stabbing
- PPP Pins & Needles
- DDD Dull/Aching
- NNN Numbness



Medical History:

Do you have any of the following (please circle)?

Diabetes, High Blood Pressure, High Cholesterol, Thyroid Disease, Cancer, HIV, Hepatitis, Seizures

If yes, please indicate when diagnosed for each condition selected _____

Surgical History:

_____	Date
_____	Date
_____	Date
_____	Date
_____	Date

For Women: Are you pregnant now? Yes/No (circle one)

Patient Name _____

Date _____

Medications/Supplements

To the best of your memory please include prescription medications, supplements, herbal supplements and over the counter (OTC) medicines you take on a regular basis

Allergies (medications, chemicals, foods, animals, insects, plants or environmental):

Family History:

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Osteoporosis					
Diabetes					
Glaucoma					

Please comment on anything else that you think is relevant.

Please check all that apply:

General

- Appetite - Poor/Excessive
- Change in appetite
- Excessive thirst
- Insomnia
- Fatigue
- Fever/Chills
- Catch cold easily
- Excessive sweating
- Night Sweats
- Localized weakness
- Poor coordination
- Bleed or bruise easily

- Thyroid - low/high
- Other _____

Musculoskeletal

- Stiff neck/shoulders
- Low back pain
- Muscle spasm/twitching/cramps
- Sore/cold/weak knees
- Joint pain
- Replacement joint/prosthesis

Skin & Hair

- Rashes/Hives
- Itching
- Eczema/Psoriasis
- Pimples/Acne
- Dryness
- Lumps/tumors

Head & Neck

- Dizziness/Fainting
- Headaches
- Concussions
- Stiff neck

Eyes

- Blurred vision
- Visual changes
- Poor night vision
- Floaters
- Cataracts
- Eye inflammation
- Glasses/Contacts
- Near/far sighted
- Other _____

Ears

- Hearing loss
- Ringing
- Infection
- Hearing aid
- Other _____

Nose, Throat, Mouth

- Nose bleeds
- Sinus infections
- Hay fever/allergies
- Recurring sore throats
- Grinding teeth
- Difficulty swallowing
- Other _____

Respiration

- Asthma
- Bronchitis
- Frequent Colds
- Chronic Obstructive Pulmonary Disease
- Pneumonia
- Chronic cough
- Coughing blood
- Phlegm production
- Other _____

Cardiovascular

- Low/high blood pressure
- Palpitations
- Blood clots
- Chest pain
- Irregular heart beat
- Cold hands/feet.
- Fainting
- Difficulty breathing
- Swelling of hands/feet
- Other _____

Gastrointestinal

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Belching
- Bad breath
- Pain/cramps
- Indigestion
- Gas
- Hemorrhoids
- Gall bladder disorder
- Blood in stool/black stool
- Other _____

Urinary

- Frequent urination
- Urgency to urinate
- Painful urination
- Unable to hold urine
- Blood in urine
- Kidney stones
- Other _____

Infectious

- HIV
- TB
- Hepatitis
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes - oral
- Herpes - genital

Neurological

- Numbness/tingling of limbs

- Pain
- Seizures
- Tremors
- Concussion
- Paralysis
- Other _____

Psychological

- Anxiety/stress
- Depression
- Irritability
- Other _____

Female

- Frequent urinary tract infections
- Frequent vaginal infections
- Pain/itching of genitals
- Abnormal pap smear
- Irregular menstrual periods
- Painful menstrual periods
- PMS
- Abnormal bleeding
- Menopausal
- Hot Flashes
- Breast tenderness/lumps
- Other _____

Male

- Pain/itching of genitals
- Weak urinary system
- Lumps in testicles
- Other _____