NEW PATIENT INFORMATION

Name_____ **M__F__Date of Birth**_____

Home Address_____

City_____**State**_____**Zip**_____ **Occupation**_____

Phone Numbers: H ( )_____ **C ( )**_____

Emergency contact _____**Relationship**_____**Phone# ( )**_____

E-mail address _____ **Referred by** _____

Main complaints_____

How long have you had these symptoms or conditions?_____

History of Illness:

__AIDS/HIV
__Anemia
__Arthritis, rheumatism
__Artificial heart valves
__Blood Disease
__Cancer
__Chemotherapy
__Circulatory problems
__Congenital heart lesions
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Headaches, migraines
__Heart murmur
__Heart problems
__Hepatitis, Type__
__Herpes
__High blood pressure
__Jaundice
__Jaw pain
__Kidney disease
__Liver disease
__Mitral valve prolapse
__Pacemaker
__Psychiatric care
__Radiation treatments
__Respiratory disease
__Special diet
__Stroke
__Thyroid problems
__Tonsillitis
__Tuberculosis
__Tumor or growth
__Ulcer
__Venereal disease

Hospitalizations, with date and cause_____
Medications you are currently taking_____
Diagnosis of your condition by your physician_____

Patient Agreement

Patient Consent

I hereby consent and authorize Jasmine Ma, Lic. Ac., to administer treatments deemed advisable and necessary to my condition in accordance with her best medical judgment. I agree to hold her free and harmless from any claims or lawsuits for damages that may arise from such treatment.

I have read and understood the above statements

Signed (Patient or Guardian)_____Date_____

Please mark to indicate if you have any of the following:

__Chest pains
__Palpitation
__Difficulty falling asleep
__Restless sleep
__Nightmares
__Night sweating
__Unusual or excess sweating

__Cough
__Shortness of breath
__Skin problems
__Sore throat
__Loss of voice
__Stiff neck
__Depression
__Pale face
__Sinus problems
__Asthma
__Fever and/or chills
__Eye problems
__Phlegm

__Stomach pain
__Gas
__Belching
__Heartburn
__Nausea
__Vomiting
__Mouth sores
__Diarrhea
__Loose stool
__Constipation
__Hemorrhoids
__Bruises easily
__Lack of appetite
__Excessive appetite
__Easily tired
__Cravings
__Desire for cold drinks
__Desire for hot drinks
__Bloating after meals

__Excessive worry
__Bitter taste in mouth
__Easily irritable or angry
__Headaches
__Muscle twitching or spasms
__Brittle nails
__Pain around the ribs
__Dizziness
__Hernia

__Hot feet or hands
__Cold feet or hands
__Swollen feet or hands
__Ringing in ears
__Deafness
__Back pain
__Knee pain
__Easily frightened
__Urinary problems
__Night urination
__Decreased sexual drive
__Poor memory
__Joint pain
__Hair loss
__Unexplained weight loss
__Other complaints or pains

For Women Only:
__Discharge between periods
__Menstrual cramps
__Excessive menstrual bleeding
__Clots
__Breast swelling or pain
__Irregular menstruation
__Taking birth control pills
__Pregnant: Due date:____

For Men Only:
__Premature ejaculation
__Impotence
__Nocturnal emissions
__Slow flow of urination
__Difficult urination
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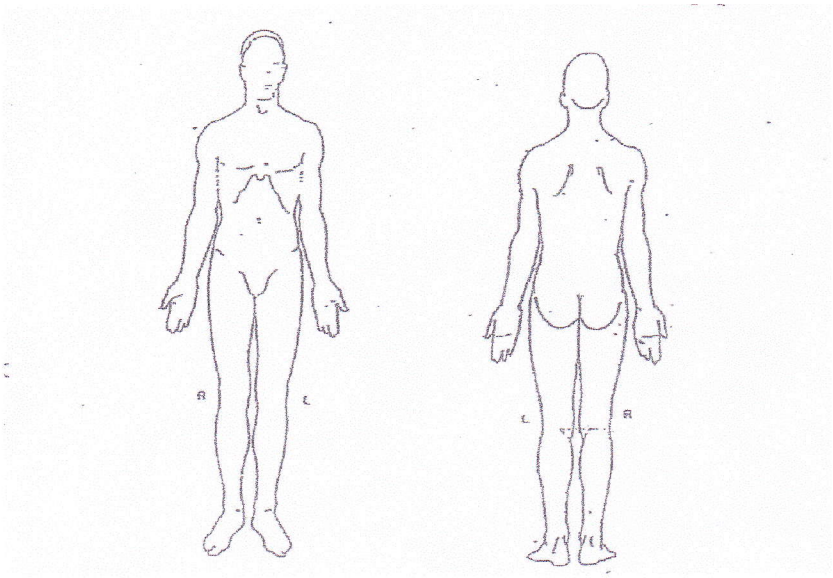
Please indicate where you are feeling pain:



Name: (printed)_____ (signed)_____Date:_____