

Patient Information

CONFIDENTIAL

Acupuncture and Oriental Medicine- Sylvia Salcedo Rojas L.Ac
*700 East 9th Ave, Suite 105 Denver CO 80203 Phone: 303- 832- 7375

Welcome to the Acupuncture and Oriental Medicine Clinic

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. The Acupuncture and Oriental Medicine Clinic considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST, MIDDLE)	DATE
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AGE	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Would you like to be placed on our mailing list to receive our newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No Your information is for our private use only
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PHONE	EMAIL ADDRESS
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HOME ADDRESS		
CITY	STATE	ZIP CODE

OCCUPATION	
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EMPLOYED BY

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE
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REFERRED BY:

The diagnosis and treatment plan I will be given by the Acupuncture and Oriental Medicine Clinic is based upon Traditional Chinese medical principles and does not constitute a western medical diagnosis. I understand that I should be evaluated by a physician for the condition I am requesting consultation. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am taking.

SIGNATURE

DATE

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A: PRIMARY COMPLAINT-

Describe your symptoms to the best of your ability: _____

B: SECONDARY COMPLAINTS- (List any other symptoms you are experiencing, whether or not it may be related to your primary complaint). _____

When did your primary complaint first occur? _____

How long or how often has it been occurring? _____

To what extent does this problem affect your daily activities (work, sleep, eating, energy, etc.)? _____

When and under what circumstances does it seem to get better? Worse? _____

Have you undergone any other treatment for this condition? _____

MEDICAL HISTORY (List relevant past illness, injuries, surgeries with dates) _____

SIGNIFICANT FAMILY MEDICAL HISTORY:(List briefly and whom) _____

II. Patient Medical History

How was your childhood health? _____

Hospital
Visits/Stays: _____

Recent tests: (please indicate test results and date below)

Physical Cholesterol Prostate Blood (which?)
HIV/STD Pap smear Mammography Other: _____

Test Results and Date: _____

Check any you have had in the past:

Diabetes Allergies Glaucoma Rheumatic Fever
Heart Disease CVA (stroke) Vein condition Thyroid disorder
Asthma Pneumonia Tuberculosis Emphysema
Jaundice Gonorrhea Mumps Bleeding tendency
Syphilis Measles Chicken pox Nervous disorder
Meningitis HIV Polio Mononucleosis
Epilepsy High fever Hepatitis Multiple Sclerosis
Paralysis Cancer Migraines High blood pressure
Other lung illnesses Other liver illnesses Other heart illnesses Other kidney illnesses
Other: _____

Immunizations: _____

Surgeries: _____

III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

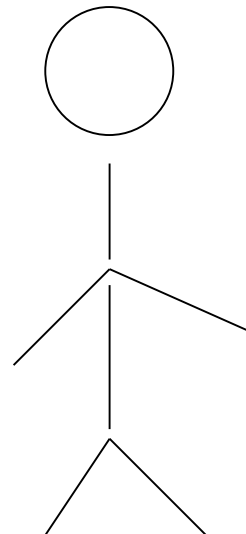
Sharp Burning Aching
Cramping Dull Moving
Fixed Other: _____

Do the following lessen the pain?

Pressure Cold Heat
Exercise Other: _____

Do the following worsen the pain?

Pressure Cold Heat Other: _____



Overall Temperature (Kidney function):

- Cold hands
- Cold fingers
- Cold feet
- Cold toes
- Sweaty hands
- Sweaty feet
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed

Spleen, Stomach, Large Intestine, Small Intestine function:

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools

Eyes (Liver function):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

Overall energy (Lung, Kidney function):

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

Heart function:

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (# of cups per week: _____)

Lung function:

- Nasal Discharge (Color: _____)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry mouth
- Dry throat
- Dry Nose
- Dry Skin
- Allergies (To what? _____)
- Alternating fever and chills
- Sneezing
- Headache (Location: _____)
- Overall achy feeling in the body
- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Smoke cigarettes (# of cigarettes per day: _____)
- Sadness
- Melancholy

Spleen function:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (previously diagnosed, which organ? _____)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

Stomach function:

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting

Dampness trapped in the body:

- General sensation of heaviness in the body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Kidney, Urinary Bladder function:

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing in the ears
- Kidney stones
- Bladder infections
- Wake during the night twice or more to urinate
- Lack of bladder control
- Fear
- Easily startled

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Painful
- Urgent
- Frequent

Libido:

- Normal
- High
- Low

Women only:

Regular menstrual cycle? Y N

Number of children: _____

Age of first menstruation: _____

Average number of days of flow: _____

Vaginal discharge

Pregnant? Y N

Number of pregnancies: _____

Age of menopause (if applicable): _____

Average number of days of entire cycle: _____

Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

nausea

vomiting

water retention

breast swelling

food cravings

headaches

migraines

breast tenderness

depression

irritability

anxiety

other emotions: _____

dull pain, where? _____

sharp pain, where? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

Swollen testes

Testicular pain

Impotence

Premature ejaculation

Feeling of coldness or numbness in external genitalia

Other _____