Daisy Dong LAc. CMD

1325 S Colorado Blvd. Suite B 012
Denver, Colorado 80222
aculifeology@gmail.com
720.245.4000

Traditional Chinese Medicine

Acupuncture, Chinese Herbology & Tui-Na,

1. About you Today's Date _____

You are (name): _____ Male ☐ Female ☐

Date of Birth: _____ Height _____ Weight _____

Home address: _____(Street)

(City) _____ (State) _____ (Zip) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Windowed ☐ Partnership

Telephone: (home) _____ (Mobile) _____

(Work) _____ (email) _____

Emergency contact person's name (print clearly): _____

Emergency contact Number: _____(Tel) Relationship to you _____

Work Status: ☐ Full time ☐ Part time ☐ Home maker ☐ Self employed ☐ Unemployed

Occupation: _____Company: _____

2. About your today's visit (check)

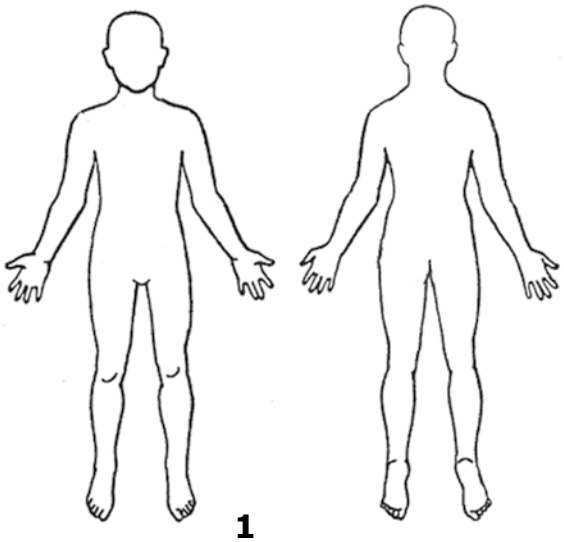
a. Injury: ☐ Auto ☐ Work ☐ Sports ☐ Fall ☐ Other

b. Illness: ☐ 2 wks ☐ 6 mo ☐ 1 years ☐ 10 years

c. Pain: ☐ Acute ☐ Chronic

d. Pain scale at this moment 0-10: _____ Describe Pain_____

Circle or X where you feel pain:



3. About your payment information

Self pay: (YES) _____(NO) _____

Please sent my bill to: _____

Auto insurance _____ Policy #_____

Worker's Compensation _____ Case # _____

Military Tri-care: _____

Other: _____

Health Insurance _____ Policy #_____

Insurance Name: _____ Insurance Phone: _____

Insurance Address: _____

Subscriber's Name _____

Subscriber's SS# _____ Subscriber's DOB: _____

Subscriber's Employer _____ Groups # _____

Name of Attorney: _____ Attorney/physician's # _____

Date Retained: _____ Co-pay amount: _____

4. About your lifestyle

Caffeine ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

Tobacco ☐ Yes ☐ No

Marijuana ☐ Yes ☐ No

Vegetarian diet ☐ Yes ☐ No

Carnivore diet ☐ Yes ☐ No

Sugar Craving ☐ Yes ☐ No

Regularly exercise ☐ Yes ☐ No such as _____

Stress from work, family, relationship or others ☐ Yes ☐ No

5. Are you taking medication? ☐ Yes ☐ No (If yes, what are you currently taking?)

Rx: _____

Supplements _____

Herbals: _____

Others _____

6. Allergies

Drug allergy: _____

Food allergy: _____

Environmental allergy: _____

7. If you are *female*, please answer these questions:

Are you currently pregnant _____ (weeks)

Your last menses started on _____

days of your menstrual cycles: _____

Any PMS or cramp pre or during menstruation? ☐ Yes ☐ No

Any miscarriage? ☐ Yes ☐ No

Are you taking contraceptive pills pills? ☐ Yes ☐ No

How many children did you give birth to? _____

Are youhaving menopausal symptoms (hot flashes/night sweats)? ❑ Yes ❑ No

8. About your *present* medical history

Regarding your pain:

Frequency: _____

Locations: _____

Nature: ☐ sharp ☐ dull ache ☐ cramping ☐ sore ☐ tightness, or _____

Your illness/pain is formally diagnosed with _____

Surgeries that related to this visit

Where: _____

When: _____

Result: _____

Treatments that you have tried for this illness/pain:

Surgery ☐ Yes ☐ No

Physical therapy ☐ Yes ☐ No

Chiropractics ☐ Yes ☐ No

Massage therapy ☐ Yes ☐ No

Prescription ☐ Yes ☐ No

Psychotherapy ☐ Yes ☐ No

Acupuncture ☐ Yes ☐ No

Herbal medicine ☐ Yes ☐ No

Other: _____

9. Other medical history: _____

Heart disease _____

Diabetes _____

Hypertension _____

Cholesterol _____

Thyroid disorder _____

Cancer _____

Bleeding disorder _____

Organ transplant _____

Patient's signature: _____ Date: _____

Guardian's signature (if patient is a minor): _____ Date: _____