

New Health Chinese Medicine Center

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<http://www.chinesemedicinecenter.com>

INFORMATION REQUIRED FOR CASE HISTORY

CHART NUMBER _____ DATE _____

PATIENT NAME _____ Sex _____
(Mr./Mrs./Miss) First Name Middle Initial Last Name

DOB _____ Age _____ Occupation _____ SSN # _____

Home Address _____

Home Phone _____ Cellular Phone _____ Business Phone _____

Guardian Name for Underage _____

Please answer each question

History of Present Illness

Chief Complaint: _____

What medicine, if any, are you taking now? _____ YES NO

Are you pregnant now? _____ YES NO

Feeling—Anxiety, Depression or Hallucination? _____ YES NO

Past Medical History

Are you now or have you been under the care of a physician during the past two years? _____ YES NO

Are you subject to profuse bleeding? _____ YES NO

Are you subject to any nervous disorder, fainting or dizziness? _____ YES NO

Are you sensitive or allergic to any drug? _____ YES NO

If yes, specify the medicine? _____

Have you had heart trouble or high blood pressure? _____ YES NO

Have you had rheumatics fever? _____ YES NO

Have you had diabetes? _____ YES NO

Have you had asthma? _____ YES NO

Have you had tuberculosis? _____ YES NO

Have you had kidney, liver gallbladder, or stomach problem? _____ YES NO

Have you experienced any unfavorable reaction from any previous medical treatment? _____ YES NO

If yes, please provide detail? _____

Family History

Medical history of other family members _____

Permission is hereby granted for necessary Acupuncture and Herbs treatment.

Patient (Guardian) Signature _____ Date _____

Note