

A Return To Health Acupuncture
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Acupuncture * Herbs * Qi Gong
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MEDICAL INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: M F Marital Status: S M O
Phone (home): _____ Work: _____
Cell: _____ Email: _____
Are you a referral? _____ Who referred you? _____

Emergency Contact : _____ Phone: _____ Relation: _____

Health Insurance: _____
Insurance ID#: _____
Spouse Name if Primary Insurance Holder: _____ DOB: _____
Employer: _____
Title: _____
Group#: _____

WORKERS COMP:
Social Security #: _____
Claim#: _____
Personal Injury#: _____
Company: _____ Adjuster: _____
Phone: _____ Address: _____
Date of Injury: _____
Referring Physician : _____ Phone : _____

MEDICAL HISTORY:

Main health issue: _____

If it is pain related please answer the pain questions.
Pain Scale: 1=Light/10=Worst

Is it SORE THROBBING SHARP ACHY HEAVY Other (circle)

Is it CONSTANT FREQUENT OCCASSIONAL Other (circle)

Where does it radiate? _____

Is it worse in with movement or rest?

How many days a week/month does this effect you?

When did it begin?

Does this problem affect your daily life (work, sleep, etc.)

CURRENT MEDICAL CONDITIONS (circle all that apply)

Cancer	Diabetes	Hepatitis B	Hepatitis C
High Blood Pressure	Thyroid Disease	Seizures	Liver Disease
Herpes	HIV	High Cholesterol	Other:

Surgeries (dates):

Significant Trauma (auto accident, fall, injuries, scars, etc):

Allergies (drugs, chemicals, pets, foods, etc:)

FAMILY MEDICAL HISTORY:

Grandparents -

Parents -

Siblings-

LIFESTYLE:

What do you do to relax? (exercise, meditate, other)

Do you take any medication, supplements, or herbs?

Please describe your average daily eating habits:

Morning -

Afternoon -

Evening -

Do you smoke?

Do you drink caffeine?

Do you consume alcohol?

How many times a week?

Do you have any food cravings?

Please circle the issues you have below:

General:

Poor Appetite
Poor Sleep
Fatigue
Fevers
Chills
Night Sweats
Sweat Easily
Tremors
Cravings
Bleeding
Bruise Easily
Weight Gain
Syndrome
Weight Loss
Energy Drops
Poor Balance

Muscle/Skeletal:

Neck Pain
Shoulder Pain
Back Pain
Knee Pain
Ankle/Foot Pain
Arm Pain
Hip Pain
Swollen Joints
Stiffness
Tendonitis
Numbness
Tingling

Weakness

Gastro:

Gas/Belching
Stomach Pain
Constipation
Diarrhea
Bad Breath
Rectal Pain
Hemorrhoids
Vomiting
Acid Reflux
Ulcer
Chron's Disease
Irritable Bowel

Cranial:

Dizziness
Glasses
Ringing in Ears
Grinding of Teeth
TMJ
Blurry Vision
Poor Vision
Headaches
Ear Aches
Poor Hearing
Eye Pain
Facial Pain/Stiffness
Chronic Sore Throats

Respiratory:

Sinus Issues
ALLERGIES
Asthma
Cough
Bronchitis
Pain with Exhale
Pain with Inhale
Wheezing
Pneumonia
Mucous/Phelgm

Heart:

High Look Pressure
Low Blood Pressure
Irregular Heartbeat
Cold Hands & Feet
Swelling of hands
Swelling of feet/ankles
Chest Pains
Fainting

Neuro:

Seizures
Poor Memory
Depression
Bad Temper
Anxiety
Frequent Urination
Bite Nails
Easily Stressed
In Therapy
Attempted Suicide

Skin:

Rash
Dandruff
Loss of Hair
Hives
Acne
New Moles
Itching

Women:

Irregular Periods
Cramps
Vaginal Discharge
Heavy Period
Light Periods
Vaginal Sores
Breast Lumps
Pregnancies
PMS
Menopause
Frequent Vaginal Infections

Men:

Prostate Issues