Eileen B. Zegar, L.Ac. MTOM, Dipl. O.M

Confidential Patient Information

Name:____Date:__________________

Date of Birth:_____/____/____ Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ P ☐

Height:_________ Weight:________ Social Security No.: _______________________________________

Phone # Home: __________________Work: ___________________Mobile:_____________________

Address: ____

City:____ State:_______________ Zip:_____________

May we contact you by email? yes ☐ no ☐ Email: ____

Emergency contact:________________________Tel:__________________Relationship______________

Referred by:______________________________Physician:____________________________________

(Do not fill in if you have provided us with a current insurance card)

Employer ____Occupation________________________

Health Insurance Info: Policy#: ____________________________Group #_________________________

Insurance company____

Policy holder:____

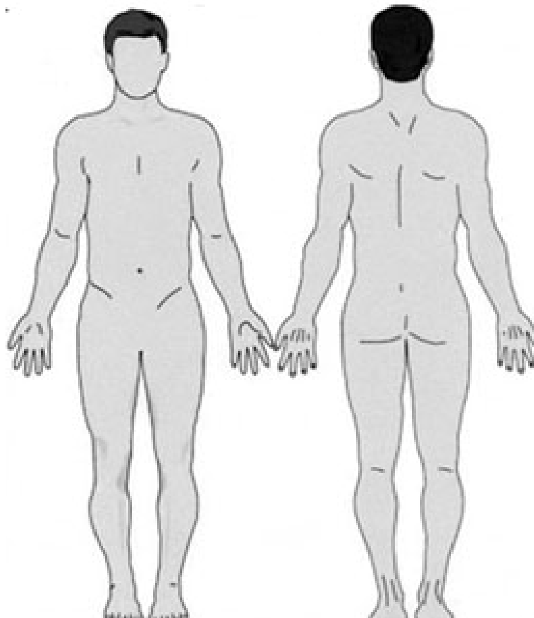
Address:____Tel.___________________________

Please list the MAIN concern that brought you here today, followed by other additional complaints. Indicate Date(s) first noticed

1. ____
2. ____
3. ____
4. ____

Please indicate with an "x" the areas where you are currently experiencing discomfort.

Draw an arrow showing the direction where the discomfort radiates.



To what extent does the problem interfere with your activities of daily living (work, exercise, sleep, sex, etc.)?____

Have you been diagnosed for this problem? If so, what?____

____

Name of physician(s) that made the diagnosis? ____

How has this condition been treated until now? ____

Do you have any known contagious diseases at this time? ________________________________

Surgeries____

____

Hospitalization or Significant Traumas____

____

Most recent physical exam____

Past Medical History (please indicate date)

- ☐ Heart Disease
- ☐ Cancer
- ☐ High Blood pressure/ High Cholesterol
- ☐ Cardiac pacemaker and or Defibrillator
- ☐ Hepatitis A, B or C
- ☐ Tuberculosis
- ☐ Benign tumors or growths
- ☐ HIV/AIDS
- ☐ STD's
- ☐ Congenital disorders
- ☐ Kidney disease
- ☐ Stroke
- ☐ Head trauma
- ☐ Epstein Barr Virus (EBV)
- ☐ Lupus Erythmatosis (SLE)
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis
- ☐ Autoimmune disorders
- ☐ Genital Herpes / Cold sores / Shingles
- ☐ Epilepsy/ Seizures
- ☐ Anemia, Blood or Bleeding disorders
- ☐ Warts, Plantar, HPV,
- ☐ Surgical implants
- ☐ Neurological disorders, peripheral neuropathy
- ☐ Osteoarthritis
- ☐ Broken bones

Please indicate your family history as it relates to the list above:

____

____

Please circle your favorite flavor: Sour Bitter Sweet Pungent Salty

Are you on any specific type of diet at this time?_____________________________________

Favorite foods?____

How many hours of sleep do you get at night_______________ Do you wake rested? ☐ yes ☐ no

Number of hours worked during an average work week: ________________________________

Do you have a regular exercise program? Please describe:_____________________________

Do you have adequate energy throughout the day? ☐ yes ☐ no

At what time of day is it highest? ______________________ lowest?______________________

Mark an "x" on the line to indicate your current stress level 0____________________________________10

How much does it affect you? 0____________________________________10

Are you happy with your current body weight? ☐ yes ☐ no

If so do you want to: ☐ increase ☐ decrease

Do you strongly prefer: ☐ room temperature drinks ☐ cold drinks, or ☐ warm or hot drinks

Number or bowel movements per day? __________ Are they: pebbles ☐ well formed ☐ sticky☐ dry ☐ alternating constipation & diarrhea ☐

Are you currently sexually active? ☐ yes ☐ no

Yes	No	Health Habits:		
☐	☐	Alcohol	Drinks per day / week______	Type____________________________
☐	☐	Tobacco	Packs per day ____________	Type____________________________
☐	☐	Recreational	Times per day/ week ______	Type____________________________
☐	☐	Coffee	Cups per day_____________	Type____________________________
☐	☐	Artificial sweeteners	Packs per day____________	Type____________________________
☐	☐	Soft drinks	Drinks per day____________	Type____________________________

Medications or Dietary supplements you are currently using:

Rx(s)/ supplement(s)	Reason	For how long?
1.		
2.		
3.		
4.		
5.		
6.		
8		
9.		
10		
11.		

Allergies/Sensitivities: (drugs, chemical, foods, fragrances.)____

____

____

Do you suffer from any of the following? (Please check all symptoms that apply)

Water Element: Kidney/ U.Bladder

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Low back or neck pain
- ☐ Sinus congestion
- ☐ Edema
- ☐ emotional instability
- ☐ aversion to cold
- ☐ hair thinning or loss
- ☐ premature aging
- ☐ frequent urination
- ☐ kidney stones
- ☐ perspire easily
- ☐weakness of legs/ knees
- ☐ asthmatic cough
- ☐ rapid weight loss
- ☐ loose teeth
- ☐ reduced sexual energy
- ☐ thyroid problems
- ☐ diabetes

Wood Element: Liver/ Gallbladder

- ☐ Headache/ Migraine, tension, other
- ☐ Migraines
- ☐ Ringing in the ears
- ☐ poor eyesight
- ☐ eye infections
- ☐ dry eyes
- ☐ eczema
- ☐ Shingles
- ☐ Herpes Simplex
- ☐ Warts
- ☐ Nervousness
- ☐ convulsions, spasms
- ☐ irritability
- ☐ constipation
- ☐ ulcer
- ☐ vomiting
- ☐ gallstones
- ☐ indecisive
- ☐ fullness below the ribs
- ☐ shoulder/ neck tension
- ☐ insomnia 11PM – 3AM

Fire Element: Heart / Sm. Intestine

- ☐ dry scalp
- ☐ skin eruptions
- ☐ cysts, tumors
- ☐ ear infections
- ☐ sore throat, tonsillitis
- ☐ lymphatic swelling
- ☐ hot palms & soles
- ☐ heart palpitations
- ☐ aversion to heat
- ☐ bitter taste in the mouth
- ☐ gum problems
- ☐ nose bleeds
- ☐ facial redness
- ☐ itching/ burning skin
- ☐ hot hands/ feet
- ☐ thirst
- ☐ vivid dreaming
- ☐ dark urine
- ☐ night sweats

Earth Element: Spleen/ Stomach

- ☐ indigestion or heartburn
- ☐ flatulence
- ☐ food allergies
- ☐ stomach pain/ ulcer
- ☐ diarrhea
- ☐ halitosis
- ☐ mouth sores
- ☐ hemorrhoids
- ☐ strong appetite
- ☐ weak appetite
- ☐ nausea
- ☐ abdominal bloating
- ☐ low body weight

Metal Element: Lung/ Lg. Intestine

- ☐ bronchitis
- ☐ asthma
- ☐ shallow breathing
- ☐ cough
- ☐ sinus congestion
- ☐ nasal infection

Other

- ☐ sciatica/ nerve pain
- ☐ cold hands/ feet
- ☐ tendonitis
- ☐ bursitis

Male:

- ☐ hernias
- ☐ testicular masses or pain
- ☐ prostate disease
- ☐ impotence
- ☐ frequent urination
- ☐
- ☐
- ☐
- ☐

Female:

Age menses began____________

- ☐ birth control
- ☐ PMS
- ☐ Irregular periods
- ☐ painful periods (dysmenorrhea)
- ☐ fibroids
- ☐ breast lumps
- ☐ endrometriosis
- ☐ light or heavy periods
- ☐ are you pregnant
- ☐ number or live births
- ☐ menopause sx__________________

(For Doctor's use only)

S	Chief complaint:
O	Physical findings:
	Tongue: Body:
	Coat:
	Pulse: Right
	Left
A	Western Dx:
	TCM Primary DX:
	Secondary:
P	Treatment Principle:
	Acupuncture Pts:
	Herbs:
	Recommended course of tx:
	Signature: Date:
	ICD9 code:
	CPT code: