Encino Town Center
17200 Ventura Blvd., Suite 314
Encino, CA 91316
818-419-9075

Beverly Hills Acupuncture
9001 Wilshire Blvd., Suite 308
Beverly Hills, CA 90211
310.486.6552

1st Defense, Inc.
www.1stdefense.info

PATIENT CONFIDENTIAL INFORMATION

Name ____ Date ____________
First Middle Last

Address ____
Street City State Zip

Home Phone _____________ Business Phone ____________ Email _________________

Age _____ Date of Birth __________ Sex ___ Marital Status: M S D W

Social Security No _______________ Driver's License No ________________ State: _______

Occupation ______________________ Employer ______________________________

Address ____
Street City State Zip

How did you find us? ☐ friend/relative ☐ website ☐ healthcare referral Referral name____________

Emergency Contact/ Relationship________________________Tel:__________________

Physician______________________________Physician's phone #___________________

CASE HISTORY

Chief Complaint ____

Complaint result of: ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other ________________

Date of condition began: ____________ If other, was onset sudden or gradual? Symptoms are relieved by ____

Have you seen any other doctor about this condition? _____ If yes, when? ______________

Doctor's Name ________________________________ Phone ______________

What medical diagnosis have you been given? ___________________________________

What medications/supplements are you currently taking? ___________________________

____

Past Medical History:

Have you had any of these conditions? Check all that apply:

☐ AIDS/HIV	☐ Alcoholism	☐ Asthma	☐ Birth Trauma
☐ Cancer	☐ Diabetes	☐ Drug Addictions	☐ Emphysema
☐ Fibromyalgia	☐ Heart Disease	☐ Hepatitis A/B/C	☐ Herpes
☐ Joint Replacements	☐ Lyme's Disease	☐ Lymph Nodes removed	☐ Multiple Sclerosis
☐ Pacemaker	☐ Polio	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Seasonal Allergies	☐ Seizures	☐ Sinus Infections	☐ Tuberculosis

☐ Allergies (food, latex) - please specify____

☐ Operations (type/date)____

☐ Other____

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother:____

Father:____

Siblings:____

Grandparents:______________________________________

Exercise & Energy:

On a scale of 1 to 10, 10 being the highest, how is your energy? _____ Please elaborate: _______________

____

What time of day is your energy: Highest?_________ Lowest?_________ Do you fatigue easily? Y N

What kind of exercise do you do?________________________________

How often do you exercise?__________________________________

Emotions & Sleep:

How do you feel emotionally?________________________________

Do you have: ☐ Panic attacks ☐ Depression ☐ Anxiety ☐ Bad temper ☐ Nervousness

☐ Fear attacks ☐ Poor memory ☐ Difficult concentration

How do you hold/handle stress?________________________________

On a scale of 1 to 10, 10 being the highest, what is your typical stress level? _______

How do you relax?______________________________________

How long do you normally sleep? _____ hours per night. I normally go to sleep about _________ pm.

I have difficulties with: ☐ Falling asleep ☐ Staying asleep ☐ Dream-disturbed sleep

☐ Waking up around _____am/pm & not being able to fall back asleep

Gastrointestinal: (check all that apply):

☐ Belching ☐ Nausea ☐ Vomiting ☐ Vomiting of blood ☐ Ulcers ☐ Bloating ☐ Acid regurgitation

☐ Heartburn ☐ Hernia ☐ Indigestion ☐ Severe stomach pain ☐ Gallstones

☐ Constipation ☐ Diarrhea ☐ Gas ☐ Burning sensation ☐ Hemorrhoids ☐ Undigested food in stool

☐ Loose stool ☐ Hard stool ☐ Blood in stool ☐ Itchiness ☐ Painful bowel movements

Bowel movements: How often? _________time(s)/day _________days/week

Urinary:

Urination Color: ☐ Pale yellow ☐ Dark yellow/orange Amount: ☐ Copious ☐ Scanty

I have or have had: ☐ Trouble starting stream ☐ Frequent urination ☐ Urgency ☐ Incontinence

☐ Pain ☐ Burning ☐ Dribbling when sneezing ☐ Blood in urine ☐ Kidney stones

☐ Urinary tract infections ☐ Other______________________________

Women:

At what age did you start menstruating? ___________Number of days between cycles:______________

Number of days of flow:____________ Color: ____________________________

I have or had (check all that apply): ☐ Irregular menstruation ☐ Heavy flow ☐ Light flow ☐ No flow ☐ Clots ☐ Vaginal itching/burning ☐ Spotting between periods ☐ Discomfort/pain before period ☐ Discomfort/pain during period ☐ Other____________________________

Vaginal discharge? ☐ No ☐ Yes If yes: Color? ___________________ ☐ Foul smelling

☐ Copious or ☐ Small amount? ☐ Thick or ☐ watery?

Men:

I have (check all that apply): ☐ Prostatitis ☐ Impotence ☐ Bloody discharge

☐ Mucous discharge - please note color, amount, and consistency ______________________________

☐ Other:____

Muscles, Joints & Bones:

Do you have pain or tightness? ☐ No ☐ Yes: Where?____

On a scale of 1 to 10, 10 being the highest, what is the level of pain you are experiencing? ________

The pain is (check all that apply): ☐ Sharp ☐ Dull ☐ Aching ☐ Numb ☐ Superficial Pain

☐ Deep Pain ☐ Burning ☐ Tingling ☐ Shooting ☐ Pain worse/better with heat

☐ Pain worse/better with cold ☐ Pain worse/better with pressure ☐ Pain worse in am/pm ☐ Constant

I have: ☐ Swollen joints ☐ Arthritis/joint pain ☐ Tendonitis ☐ Bone pain ☐ Muscle cramping

☐ Muscle pain ☐ Repetitive Strain Injury ☐ Fractured Bone(s) Where?__________________________

☐ Other____

Eyes, Ears, Nose, Throat, & Head:

Do you smoke? ☐ No ☐ Yes ____________per day, for ________years

I have (check all that apply): ☐ Frequent colds ☐ Chronic runny nose ☐ Frequent sore throat

☐ Chronic cough ☐ Coughing blood ☐ Cough up mucous ☐ Pain inhaling

☐ Shortness of breath on exertion/at rest ☐ Asthma ☐ Nose bleeds ☐ Painful/red eyes ☐ Poor vision

☐ See spots/floaters ☐ Dizziness ☐ Cold sores ☐ Bleeding gums ☐ Dry mouth ☐ Ear pain

☐ Ringing in ears ☐ Clogged/popping in ears

☐ Frequent headaches/migraines. Describe location, intensity, type of pain, frequency, and initiating factors if known: ____

____

Cardiovascular:

I have (check all that apply): ☐ Chest pain ☐ Palpitation ☐ Varicose veins ☐ Phlebitis

☐ Cold hands and feet ☐ Irregular heart beat ☐ Poor circulation

☐ Other:____

Skin & Hair:

I have or often have (check all that apply): ☐ Dry skin ☐ Skin rashes ☐ Itching ☐ Acne

☐ Eczema ☐ Hives ☐ Hair loss ☐ Premature graying ☐ Other:___________________________