ACUPUNCTURE FOR LIFE, LLC

2290 E 4500 So. Suite 110, Holladay, Utah, 84117
Tel . (801) 673-6795

Sagrario Cordero, MS, L.Ac

(Please Print)

Primary Phone _____ E-mail: _____

PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Sex ❒ M ❒ F Age _____ Birthday _____

Driver License No. _____ Social Security No. _____

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Spouse's Name _____ Phone _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

In case of emergency, whom should we notify? _____

Relationship _____ Phone _____

Address _____

Primary Physician _____ Phone _____

Address _____

Whom may we thank for referring you? _____ Phone _____

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PATIENT HISTORY

1. What is your chief complaint? _____

2. How did this condition develop? _____

3. How long has this condition persisted? _____

4. Have you ever received any treatment for this condition? ❒ Yes ❒ No
   If yes, where? _____
   When? _____
   By whom? _____
   What was the diagnosis? _____
   What kind(s) of treatment(s)? _____
   What were the results of treatment? _____

5. Please list substances that you are allergic to _____
   _____

6. (Female only) Are you pregnant or do you suspect that you may be pregnant?_____

7. List medications you are currently taking.

Medications	Strength	How many per day	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Have you tried acupuncture or Chinese medicine before? ❒ Yes ❒ No

9. List any major surgeries you have had.

Date	Problem
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10. Significant illness: (please check)
    ❒ Rheumatic Fever ❒ Heart Disease ❒ Diabetes
    ❒ Thyroid Disease ❒ Cancer ❒ Hepatitis
    ❒ High Blood Pressure ❒ Aids ❒ Seizures
    ❒ Venereal Disease ❒ Other _____

11. Significant Trauma (auto accident, falls, etc.) _____
    _____
    _____

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HEALTH HISTORY

(confidential)

Name _____ Today's Date _____

Please check (✓) symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fevers
- ☐ Forgetfulness
- ☐ Headache
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Weight gain
- ☐ Weight loss

Eye, Ear, Nose, Mouth, Throat
- ☐ Blurred vision
- ☐ Bleeding gums
- ☐ Cataracts
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Eye pain/strain
- ☐ Glasses
- ☐ Hay fever
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Olfactory problems
- ☐ Recurrent sore throat
- ☐ Red / Inflamed eye
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sores on lips / tongue
- ☐ Taste change
- ☐ Teeth problems
- ☐ Vision – halos

Respiratory
- ☐ Asthma
- ☐ Coughing blood
- ☐ Night sweats
- ☐ Persistent cough
- ☐ Phlegm production
- ☐ Recurrent bronchitis
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black stools
- ☐ Bloating
- ☐ Blood in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Gas
- ☐ Heartburn / Reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor appetite
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Genitourinary
- ☐ Abnormal urine color
- ☐ Blood or pus in urine
- ☐ Burning urination
- ☐ Frequent urination
- ☐ Kidney stone
- ☐ Poor bladder control
- ☐ Urgency to urinate

Musculoskeletal

Pain, weakness, and/or numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Joints
- ☐ Legs
- ☐ Muscle
- ☐ Neck
- ☐ Shoulders

Skin
- ☐ Blood not clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Lumps in groins
- ☐ Lumps underarm
- ☐ Skin problem

Neurological
- ☐ Convulsions
- ☐ Fainting
- ☐ Handwriting change
- ☐ Paralysis
- ☐ Tremor / clumsiness
- ☐ Vertigo / drowsiness

Men Only
- ☐ Breast lump
- ☐ Genital pain
- ☐ Impotence
- ☐ Lump in testicles
- ☐ Penis discharge

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Contraceptives
- ☐ Irregular periods
- ☐ Menopausal
- ☐ Painful periods
- ☐ Sores on genitalia
- ☐ Vaginal discharge

Number of:
- ____ Pregnancies
- ____ Miscarriages
- ____ Children
- ____ Abortions

Date of:

Last menstrual period:_____

_____

Last Pap Smear:

_____

Have you had a mammogram?

_____

Are you pregnant?

_____