113 N. Second Avenue
St. Charles, IL 60174
www.relaxattranquility.com

Please fill out completely and carefully.

Date: _____

General Patient Information

Name:		
Address		
City, State, Zip		
Home Phone:	Work Phone:	
Cell Phone:	Email:	
Preferred method of contact: ☐ home ☐ work ☐ email		
Date of Birth:	Age:	
Gender: ☐ M ☐ F	Single: ☐	Married: ☐
Height:	Weight:	
Occupation:		
How did you hear about us?		
Emergency Contact:		
Phone:	Relationship of above person	

Consent to Treatment and Financial Responsibility

My signature below indicates my consent to be treated with Complementary and Oriental medicine methods, including but not limited to Acupuncture, Chinese or Western herbal therapy and/or related modalities. I understand that payment is due in full at the time of service and that I may request a bill to submit to my insurance.

Signature of Patient/Legal Guardian: _____

Date: _____

Patient Name:_____

Check if you have any of the following conditions and indicate whether presently or in the past:

Condition	Past	Presently	Condition	Past	Presently
☐ Diabetes	☐	☐	☐ Pneumonia	☐	☐
☐ Allergies	☐	☐	☐ STD	☐	☐
☐ Glaucoma	☐	☐	☐ Epilepsy	☐	☐
☐ Rheumatic Fever	☐	☐	☐ Paralysis	☐	☐
☐ Heart Disease	☐	☐	☐ HIV	☐	☐
☐ Stroke	☐	☐	☐ TB	☐	☐
☐ Jaundice	☐	☐	☐ Mumps	☐	☐
☐ Chicken pox	☐	☐	☐ Polio	☐	☐
☐ Shingles	☐	☐	☐ Migraines	☐	☐
☐ Thyroid Disorder	☐	☐	☐ Emphysema	☐	☐
☐ Bleeding tendency	☐	☐	☐ Mononucleosis	☐	☐
☐ High blood pressure	☐	☐	☐ Kidney stones	☐	☐
☐ Urinary Infection	☐	☐	☐ Anemia	☐	☐
☐ Cancer	☐	☐	☐ Sleep Apnea	☐	☐
☐ Liver disorder	☐	☐	☐ Hepatitis	☐	☐

Check if you have had these Immunizations:

- ☐ Chicken pox
- ☐ Measles
- ☐ TB
- ☐ Tetanus (in last 10 years)

List any surgeries and approximate date you had them:

- ☐ Tonsillectomy _____
- ☐ Knee surgery _____
- ☐ Hysterectomy _____
- ☐ Vasectomy _____
- ☐ Bladder Mesh _____
- ☐ Back surgery _____
- ☐ Hip surgery _____
- ☐ Tubal Ligation _____
- ☐ Cancer surgery _____
- ☐ Other _____

Please describe your pain:

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Dull
- ☐ Cramping
- ☐ Moving
- ☐ Constant
- ☐ Intermittent
- ☐ Fixed

Do the following affect your pain?

	Makes it Worse	Makes it Better	Does Not Affect Pain
☐ Heat	☐	☐	☐
☐ Cold	☐	☐	☐
☐ Pressure	☐	☐	☐
☐ Exercise/Movement	☐	☐	☐

Men Only

- ☐ Swollen testes
- ☐ Impotence
- ☐ Coldness/numbness- external genitalia
- ☐ Unusual discharge from penis
- ☐ Testicular pain
- ☐ Premature ejaculation
- ☐ Erectile dysfunction
- ☐ Other _____

Patient Name:_____

Women Only

Pregnancies _____ # Children_____

- ☐ Regular menstrual cycle
- ☐ Irregular menstrual cycle
- ☐ Average # days of flow
- ☐ Severe menstrual cramps
- ☐ Mild menstrual cramps
- ☐ PMS symptoms
- ☐ Age at first menses _____
- ☐ Age at menopause _____
- ☐ Average # days entire cycle _____
- ☐ Unusual vaginal discharge
- ☐ Bleeding between periods
- ☐ How soon before flow starts? _____

*Please check the categories that **currently** apply to you*.

Qi, Kidney, Heart and Lung Function

- ☐ Low Energy/Fatigue
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Difficulty keeping eyes open in daytime
- ☐ Feel worse after exercise
- ☐ Achiness all over body
- ☐ Low libido
- ☐ Skin often damp or moist
- ☐ Cold body temperature
- ☐ Cold sensation in knees
- ☐ Get chilled to the bone
- ☐ Afternoon flushes or hot flashes
- ☐ Night sweats
- ☐ Heat in the hands, feet, and chest
- ☐ Hot flashes throughout day or night
- ☐ Headaches
- ☐ Migraines
- ☐ Seasonal allergies
- ☐ Continuous allergies (dust, etc.)
- ☐ Sinus congestion
- ☐ Nasal discharge
- ☐ Dry lips, mouth, nose or throat
- ☐ Itchy eyes
- ☐ Dry eyes
- ☐ Watery eyes
- ☐ Floaters/ decreased night vision
- ☐ Chest pain
- ☐ Chest pain radiating to shoulder
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Nightmares
- ☐ Do not feel refreshed on awakening
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Chest congestion/Asthma
- ☐ Heaviness in body
- ☐ Mental heaviness
- ☐ Mental fogginess
- ☐ Dizziness
- ☐ Swollen joints
- ☐ Swelling or edema
- ☐ Excessive libido
- ☐ Difficulty urinating
- ☐ Overly warm body temperature
- ☐ Alternating fever/chills
- ☐ Take water to bed
- ☐ Excessive thirst
- ☐ Easily perspire/excessive perspiration
- ☐ Rarely perspire
- ☐ Graying hair
- ☐ High pitched ringing in ears
- ☐ Low pitched ringing in ears
- ☐ Ear aches
- ☐ Mouth sores
- ☐ Tongue sores
- ☐ Bad breath
- ☐ Bleeding, swollen or painful gums
- ☐ Sore throat
- ☐ Phlegm in throat
- ☐ Difficulty swallowing
- ☐ Jaw pain (TMJ)
- ☐ Anxiety
- ☐ Restlessness
- ☐ Palpitations
- ☐ Sores on tip of tongue
- ☐ Varicose or spider veins
- ☐ Chest tightness
- ☐ Sadness/Melancholy
- ☐ Dry/Cracked Skin
- ☐ Tobacco use
  - Packs/day _____

Patient Name:_____

Please check the categories that **currently** apply to you.

Digestive Function - **Spleen, Stomach, Intestines**

- ☐ Diminished Appetite
- ☐ Excessive appetite
- ☐ Abrupt weight gain/loss
- ☐ Fatigue after eating
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Over-thinking
- ☐ Worry
- ☐ Nose bleeds
- ☐ Other bleeding
- ☐ Prolapsed organs
- ☐ Loose stools
- ☐ Blood in stools
- ☐ Incomplete BM
- ☐ Alternating diarrhea and constipation
- ☐ Feel worse after BM
- ☐ Acid reflux
- ☐ Heart burn
- ☐ Stomach pain
- ☐ Nausea/vomiting
- ☐ Gassy
- ☐ Hiccups/belching
- ☐ Ulcers (diagnosed)
- ☐ Burning sensation after eating
- ☐ Feel better after eating
- ☐ Feel worse after eating
- ☐ Abdominal bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Mucous in stools
- ☐ Undigested food in stools
- ☐ Feel better after BM

Liver, Gallbladder, Urinary Function

- ☐ Frequent cavities, dental problems
- ☐ Easily broken bones
- ☐ Weakness in low back
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Dark yellow urine
- ☐ Reddish urine/ blood in urine
- ☐ Cloudy urine
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Interrupted urination
- ☐ Weak stream
- ☐ Kidney stones
- ☐ Wake at night to urinate 2x or more
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled
- ☐ Burning urination
- ☐ Painful urination
- ☐ Difficult to urinate
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Strong odor or discharge
- ☐ Bladder infections

Lifestyle Choices

- ☐ Cups coffee or tea/day _____
- ☐ Ounces soda/day _____
- ☐ Ounces water/day _____
- ☐ Food allergies _____
- ☐ Use artificial sweeteners _____
- ☐ Exercise How often? _____

Medications/Vitamins

- ☐ Aspirin
- ☐ Diuretics
- ☐ Antacids
- ☐ Antibiotics
- ☐ Birth Control
- ☐ Multivitamin
- ☐ Calcium
- ☐ Cough Meds
- ☐ Thyroid Medicine
- ☐ Coumadin
- ☐ Cortisone
- ☐ Heart Meds
- ☐ Vitamin C
- ☐ Magnesium
- ☐ Asthma Meds
- ☐ Weight Loss
- ☐ Hormones
- ☐ Insulin
- ☐ Laxatives
- ☐ Vitamin D
- ☐ Iron
- ☐ Blood Pressure
- ☐ NSAIDs
- ☐ Pain Meds
- ☐ Sleep Aids
- ☐ Tranquilizers
- ☐ Vitamin B
- ☐ Other _____