



www.beachacu.com

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Welcome to BCA!

Patient Information and Health History

Date _____ Name _____ Address _____ City, State, Zip _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email: _____ Have you had acupuncture before? _____	Sex M F Age _____ Birth date _____ Are you currently : Employed Retired Disabled Occupation _____ Employer _____ Primary Physician _____ Physician Phone _____ Emergency Contact Name: _____ Emergency Contact Phone: _____ How did you find out about us? _____
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Major Complaint(s), in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you received a diagnosis for you condition(s)? Y / N
 If so, what diagnosis?

By whom? _____

When / how did these conditions occur? (provide dates if possible)

How do these conditions impair your daily activities?

Treatment(s) that you have received for these conditions?

When was your last complete medical exam?

PAST MEDICAL HISTORY

AIDS or HIV+	Y / N	Blood Transfusions	Y / N
Hepatitis	Y / N	Tuberculosis	Y / N
Measles	Y / N	Infectious Mono	Y / N
Hernia	Y / N	Headaches	Y / N
Hives or Eczema	Y / N	Heart Disease	Y / N
Allergies	Y / N	Diabetes	Y / N
Mumps	Y / N	Bleeding tendency	Y / N
Kidney Disease	Y / N	Rheumatic Fever	Y / N
High Blood Pressure	Y / N	Low Blood Pressure	Y / N
Whooping Cough	Y / N	High Cholesterol	Y / N
Cancer	Y / N	Anemia	Y / N
Mitral Valve Prolapse	Y / N	STD's	Y / N
Scarlet Fever	Y / N	Polio	Y / N
Stroke	Y / N	Thyroid Disease	Y / N
Eating Disorder	Y / N	Drug/Alcohol Addiction	Y / N

Any other disease (please list) _____

Medications/Supplements

Name	Purpose	Dose	How Often

Accidents or Surgeries

Please list below, with dates...

PLEASE TURN OVER AND COMPLETE BACK SIDE

Rate each symptom on a scale of 1-5 (5 being the worst). If not applicable, leave blank.

<input type="checkbox"/> Bloody Cough <input type="checkbox"/> Dry Cough <input type="checkbox"/> Cough with sputum <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Post-nasal drip <input type="checkbox"/> Sinus infection <input type="checkbox"/> Congestion <input type="checkbox"/> Red, sore, itchy throat <input type="checkbox"/> Dry mouth, throat, nose <input type="checkbox"/> Skin rashes, hives <input type="checkbox"/> Snoring <input type="checkbox"/> Grief / Sadness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Allergies / Asthma <input type="checkbox"/> Low resistance to colds / flu <input type="checkbox"/> Sneezing <input type="checkbox"/> Mild fever comes / goes <input type="checkbox"/> Smoke cigarettes <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Black stools / blood in stool <input type="checkbox"/> Constipation <input type="checkbox"/> IBS <input type="checkbox"/> Colitis <input type="checkbox"/> Spastic colon <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Indigestion <input type="checkbox"/> Excessive Worry <input type="checkbox"/> Brain Fog <input type="checkbox"/> Tendency to gain weight <input type="checkbox"/> Do You Crave: Sweet <hr/> <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Insomnia / Sleep disturbances <input type="checkbox"/> Chest Pain <input type="checkbox"/> Easily Startled <input type="checkbox"/> Restlessness / Agitation <input type="checkbox"/> Vivid Dreams <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Do You Crave: Bitter <hr/> <input type="checkbox"/> Urinary Problems <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Dropped Bladder <input type="checkbox"/> Incontinence <input type="checkbox"/> Lack of Bladder <input type="checkbox"/> Weakness/ Pain in Lower Back <input type="checkbox"/> Decrease Bone Density <input type="checkbox"/> Feel Cold Easily <input type="checkbox"/> Cold Hands <input type="checkbox"/> Cold Feet <input type="checkbox"/> Grief / Sadness <input type="checkbox"/> Low Sex Drive / Libido <input type="checkbox"/> Excess Sexual Desire <input type="checkbox"/> Poor Memory <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Hearing Difficulties <input type="checkbox"/> Excessive Cavities <input type="checkbox"/> Fear <input type="checkbox"/> Hot Flash / Night Sweats <input type="checkbox"/> Do You Crave: Salty	<input type="checkbox"/> Irritability / Anger <input type="checkbox"/> Depression / Stress <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Visual Problems <input type="checkbox"/> Red / Dry / Itchy Eyes <input type="checkbox"/> Gall Stones <input type="checkbox"/> Dizziness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Feeling of Lump in Throat <input type="checkbox"/> Clenching of Teeth at Night <input type="checkbox"/> Muscle Cramping <input type="checkbox"/> Twitching <input type="checkbox"/> Tension <input type="checkbox"/> Joints/Neck/Shoulder Pain/Tight <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Soft / Brittle Nails <input type="checkbox"/> Emotional Eater <input type="checkbox"/> Bad Taste <input type="checkbox"/> Bad Breath <input type="checkbox"/> Do you Crave: Sour <hr/> <p>Symptoms you have now or have had in past year:</p> <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Focusing <input type="checkbox"/> Easily Startled <input type="checkbox"/> Excessive Worry <input type="checkbox"/> Excessive Anger <input type="checkbox"/> Excessive Fear <input type="checkbox"/> Fatigue/Tiredness <input type="checkbox"/> Loss of Sleep/Poor Sleep <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Nervousness <input type="checkbox"/> Irritability <input type="checkbox"/> Overwhelmed by Life
<input type="checkbox"/> Heaviness anywhere in body <input type="checkbox"/> Fatigue <input type="checkbox"/> Difficulty waking in morning <input type="checkbox"/> Muscle fatigue <input type="checkbox"/> Edema <input type="checkbox"/> Easily to bruise and bleed <input type="checkbox"/> Bad Breath <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Gas / Belching <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea		

<p>For Women Only</p> <input type="checkbox"/> Bleeding in Between Periods <input type="checkbox"/> Clots in Menses <input type="checkbox"/> Excessive Menstrual Flow <input type="checkbox"/> Very Light Menstrual Flow <input type="checkbox"/> Extreme Menstrual Pain <input type="checkbox"/> History of Fibroids <input type="checkbox"/> History of Endometriosis <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Menopausal Symptoms <input type="checkbox"/> PMS <p>COULD YOU BE PREGNANT? Y/N</p>	<p>Pain in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Knees <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <input type="checkbox"/> Hips <p>Other: _____</p>	<p>Muscles/Joints/Bones</p> <input type="checkbox"/> Tremors <input type="checkbox"/> Cramps <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Weakness or Numbness in Body <p>Where? _____</p>
<p>For Men Only</p> <input type="checkbox"/> Erection Difficulty <input type="checkbox"/> Penis Discharge <input type="checkbox"/> Prostate Trouble		<p>Anything else you'd like us to know:</p>

"The information on this form is correct to the best of my knowledge."
 Signature: _____ Date: _____