ORANGE CLOVER
HOLISTIC CENTER
ACUPUNCTURE & HERBAL MEDICINE

Orange Clover Holistic Center
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**Please complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.**

# New Patient Medical Report

## General Information

Name________________________________________ Birth date_____/_____/_____Age_____Gender____
First Last

Adress______________________________________________________________________

City______________________________State___________Zip______________

E-Mail______________________________________________________________________

(May IC Oriental Clinic send you emails about clinic events and newsletters? ☐ Yes ☐ No)

Cell Phone (Primary)_________________________ Home Phone (Alternate) _________________________

(May IC Oriental Clinic call or leave a text message for appointment reminder? ☐ Yes ☐ No)

~~SSN#~~__________________ Occupation_________________________Marital Status___________

Emergency Contact______________________________Relationship______________________

Emergency Contact Phone Number__________________________________________________

Health Insurance Company________________________________________________________

Primary policy holder Name___________________ Date of Birth______________Relation to patient_____________

How did you hear about us?

☐Current Patient ☐Primary Care Provider ☐ Advertisement ☐ Insurance ☐ Internet ☐ Other_____________

Have you had Acupuncture before? ☐ Yes ☐ No

Did you have a positive ☐ Experience ☐ Outcome ☐ Did not help

Do you want to know more about IC Oriental customize herb decoction program? ☐ Yes ☐ No

| **Major Complaint(s), in order of importance to you:** | Severe | Moderate | Slight |
|---|---|---|---|
| 1.__________________________________________ | ☐ | ☐ | ☐ |
| 2.__________________________________________ | ☐ | ☐ | ☐ |
| 3.__________________________________________ | ☐ | ☐ | ☐ |
| 4.__________________________________________ | ☐ | ☐ | ☐ |
| 5.__________________________________________ | ☐ | ☐ | ☐ |

Does anything make the condition better? ☐ Yes ☐ No If yes, what?

______________________________________________________________________

Does anything make the condition worse? ☐ Yes ☐ No If yes, what?

______________________________________________________________________

Are you currently being treated for these medical problems? ☐ Yes ☐ No If yes, please describe

______________________________________________________________________

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**List any serious disease, injuries, surgeries, or hospitalizations you have had and the year they occurred:**

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Family History** (List any family physical or mental illnesses):

Mother______________________________________________________________________________

Father______________________________________________________________________________

Grandparents_________________________________________________________________________

**Medication, Herbs, Supplements** (List those you are currently taking):

Name________________________Reason_______________________How long and Dose________________

Name________________________Reason_______________________How long and Dose________________

Name________________________Reason_______________________How long and Dose________________

Name________________________Reason_______________________How long and Dose________________

## Female Only

Hysterectomy-Ovaries Removed? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Number of: _______ Pregnancies ______Births

_______ Miscarriages ______ Abortions

Age of first menses ____________

When did you last period start? ______________

Number of days for menstrual cycle? ___________

Number of days bleeding lasts? ____________

Irregular Periods:

☐ Yes ☐ No

Describe Menstrual Flow:

☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills

☐Spermicides ☐ Barriers

**Do You Suffer From:**

☐ Cramping *(Marks as appropriate)*

☐ Cramping in Low Back ☐ In Groin Area

☐ Severe ☐ Moderate

☐ Mild ☐ Before Period

☐ During Period ☐ After Period

☐ Do you feel ovulation? ☐ Do you use Pain Medication?

What kind?_______________

☐ Clotting *(Mark as appropriate)*

☐ Bright in Color ☐ Brown / Grainy

☐ Dark in Color ☐ Stringy

Size of Clots: ☐Nickel ☐ Dime ☐ Larger

☐ Bleeding Between Periods ☐ Pelvic Inflammation Disease ☐ Infertility

☐ Ovarian Cysts ☐ STD's ☐ Hot Flashes

☐ Endometriosis ☐ Breast Cysts ☐ Mastitis

☐ Yeast Infection / Vaginitis / Other discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*

☐ Swollen or tender breasts ☐ Cravings ☐ Acne

☐ Irritability/ Mood Swing ☐ Depression/ Anxiety ☐ Fatigue

☐ Diarrhea ☐ Constipation ☐ Upset Stomach/ Bloating

**Thank you for completing this form.**

**Your time is greatly appreciated and we value this opportunity to serve you.**