Welcome to The Traditional Chinese Medical Clinic of Dr. Jan Ellison

We are glad you are here. Please take a moment to complete the following information which will assist us in providing you with quality services.

Thank you!

Name _____ Birthday _____ Age _____ Occupation _____

Address _____

E-Mail Address _____ Website _____ Marital Status _____

Home Phone Number _____ Work Phone Number _____ Referred To Us By _____

Emergency Contact Name and Number _____

Main Reason For Visit Today _____

Onset Of This Condition? _____ Is It Worsening? _____

What Seems To Make It Better? _____

What Seems To Make It Worse? _____

Are you Under A Dr's Care? yes no For What? _____

Physician Name and Number? _____

Other Practitioners You are Currently Seeing (Chiropractor, MT, DOM, etc.) _____

_____

Have You Had Acupuncture? yes no When? _____ Chinese Herbal Medicine? yes no When? _____

Family Medical History (please indicate (m) mother, (f) father, (s) sibling)

Allergies _____ Cancer _____ High Blood Pressure _____

Arteriosclerosis _____ Diabetes _____ Seizure Disorder _____

Asthma _____ Emphysema _____ Stroke _____

Alcoholism _____ Heart Disease _____

Your Past Medical History (Indicate any of the following conditions you currently have or have had in the past)

AIDs/Hiv _____ Diabetes _____ High Blood Pressure ___ Scarlet Fever _____

Alcoholism _____ Emphysema _____ Measels _____ Seizure Disorder _____

Allergies _____ Epilepsy _____ Multiple Sclerosis _____ STD _____

Appendicitis _____ Goiter _____ Mumps _____ Thyroid Disorder _____

Arteriosclerosis _____ Gout _____ Pacemaker _____ TB _____

Asthma _____ Heart Disease _____ Pneumonia _____ Ulcers _____

Cancer _____ Hepatitis _____ Polio _____

Chicken Pox _____ Herpes _____ Rheumatic Fever _____

Surgeries (list each surgery including the date performed) _____

_____

Major Trauma(s) (car accidents, falls, etc. Be specific and include dates) _____

_____

Your Diet

Appetite: Low Average High How has this recently changed? _____

List any cravings you are experiencing: _____

Do you use any of the following? Caffeine _____ Artificial Sweetner _____ Meat _____ Regular Soft Drinks _____ Sugar _____

Salt _____ Diet Soft Drinks _____ Dairy _____

How many glasses of water do you drink per day? _____

List all pharmaceuticals you have taken in the past 60 days: _____

_____

List all vitamins/supplements taken in the past 60 days: _____

Your Lifestyle (please indicate if current or past use)

Alcohol____ Marijuana____ Stress____ Type of Regular Exercise____ Frequency____

Tobacco____ Recreational Drugs____ Abuse of legal drugs____ Type of Regular Exercise____ Frequency____

General Symptoms

Strongly Like Cold Drinks____ Strongly Like Hot Drinks____ Recent weight loss/gain____ Fatigue____ Weakness____

Bodily Heaviness____ Insomnia ____ Heavy Sleep____ Dream-Disturbed Sleep____

Cold Hands or Feet____ Shortness of Breath____ Fever____ Chills____ Sweat Easily____

Night Sweats____ Muscle Cramps ____ Vertigo or Dizziness ____ Bleed or Bruise Easily____

Head, Eyes, Ears, Nose and Throat

Corrective Lenses____ Eye pain ____ Itchy Eyes ____ Spots in Vision____ Blurred Vision____

Night Blindness____ Glaucoma ____ Cataracts____ Dental Problems____ Grinding Teeth____

TMJ ____ Facial Pain____ Gum Problems____ Dry Mouth____ Excessive Saliva____

Sores in/on mouth____ Sinus Problems ____ Excessive Phlegm/color____ Frequent Sore Throat ____

Swollen Glands ____ Enlarged Thyroid ____ Nose Bleeds ____ Ringing in Ears ____ Earaches ____

Poor Hearing ____ Headaches____ Migraines____ Concussions____ Other____

Respiratory

Difficulty Breathing When Lying Down____ Shortness Of Breath____ Tight Chest____ Asthma/Wheezing____

Cough ____ Wet or Dry____ Color of Phlegm____ Coughing up Blood____ Pneumonia ____

Cardiovascular

High Blood Pressure____ Low Blood Pressure____ Chest Pain ____ Tachycardia____ Bradycardia ____

Blood Clots____ Fainting____ Difficulty Breathing____ Heart Palpitations ____ Murmur ____

Gastrointestinal

Nausea/vomiting____ Acid reflux____ Excessive Gas ____ Bloating____ Bad Breath____ Diarrhea____

Constipation____ Laxative Use ____ Black Stools____ Bloody Stools____ Mucus in Stools____ Itchy Anus ____

Intestinal Pain____ Burning Anus____ Rectal Pain____ Hemorrhoids ____ Anal Fissures____

Musculoskeletal

Neck/Shoulder Pain ____ Upper Back Pain____ Lower Back Pain____ Joint Pain____ Muscle Pain ____

Rib Pain____ Limited Range of Motion ____

Skin and Hair

Rashes____ Hives____ Ulcerations____ Acne____ Psoriasis____ Eczema____ Dandruff____

Itchy Scalp____ Hair Loss____ Change in Skin/Hair Texture____ Fungal Infections ____

Neuropsychological

Numbness____ Tics____ Poor Memory____ Depression____ Anxiety____ Irritability____

Abuse Survivor____ Considered/attempted Suicide____ Seeing a Therapist ____

Genitourinary

Frequent Urination____ Pain on Urination____ Urgency____ Blood in urine____ Incontinence____

Incomplete Urination____ Bed Wetting____ Wake to Urinate____ Venereal Disease____ Kidney Stone____

Increased Libido ____ Decreased Libido____ Impotence____ Premature Ejaculation____ Genital Sores ____

Gynecology

Irregular Periods____ Painful Periods____ PMS____ Clotty Periods____ Age Menses Began____

Length of Cycle (day 1 to day1)____ Duration of Flow ____ Vaginal Odor____ Vaginal Discharge____

Breast Lumps ____ Number of Pregnancies____ Number of Live Births ____ Age at Menopause____

Date of Last Pap____ Date of Last Period ____

Other

_____

_____