# Lim's Acupuncture & Traditional Chinese Medicine

New Patient Information

17530 Ventura Blvd, Suite 220, Encino, CA 91316 * Phone: (818) 990-9990 * Email: dr.lim@lims-acupuncture-tcm.com * Web: www.lims-acupuncture-tcm.com

*Your completed patient intake forms help us to get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (818) 990-9990 if you have any questions or are unsure how to complete any section of this form.*

**Person filling out this form (if not the client):** Name: _____

Relationship to Patient: _____

## Patient Information

| | | | |
|---|---|---|---|
| Patient Name (First, Middle Initial, Last): | | | |
| Preferred Name (if different): | | Preferred Pronouns: | |
| Date of Birth: | Age: | Height: | Weight: |

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male or Man/FTM ☐ Transgender Female or Woman/MTF ☐ Genderqueer ☐ Other ☐ Choose not to disclose

Sex assigned at Birth: ☐ Male ☐ Female ☐ Choose not to disclose

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

| | | | |
|---|---|---|---|
| Street Address: | | | |
| City: | | State: | Zip: |
| Primary Phone: ( ) | ☐ Home | ☐ Mobile | ☐ Work |
| Alternate Phone: ( ) | ☐ Home | ☐ Mobile | ☐ Work |
| Email: | Preferred Method of Contact: | ☐ Primary Phone ☐ Alternate Phone ☐ Email | |
| Occupation: | Employer: | | |

## Emergency Contact

| | |
|---|---|
| Name: | Relationship: |
| Primary Phone: ( ) | Alternate Phone: ( ) |

## Referral

How were you referred to our clinic? ☐ Doctor ☐ Family ☐ Friend ☐ Patient ☐ Insurance Co. ☐ Website ☐ Advertising ☐ Other

| | |
|---|---|
| Referring Physician: | Primary Care Physician: |
| Specialty: | Specialty: |
| Phone: ( ) | Phone: ( ) |
| City: | City: |

Please check which of these treatments you have experienced before: ☐ Acupuncture ☐ Electro-Acupuncture ☐ Cupping ☐ Moxibustion ☐ Chinese Herbs ☐ None of the Above

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| Primary Insurance Plan (if applicable) | | |
|---|---|---|
| Insurance/Payer: | | Plan: |
| Address: | | |
| Phone: ( ) | Policy/ID #: | Group #: |
| Policy/I.D. Number: | | Group Number: |
| Relationship to Policyholder: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____ | | Policy Holder Name: (if not self): |
| | | Policy Holder D.O.B. (if not self): |

| Secondary Insurance Plan (if applicable) | | |
|---|---|---|
| Insurance/Payer: | | Plan: |
| Address: | | |
| Phone: ( ) | Policy/ID #: | Group #: |
| Policy/I.D. Number: | | Group Number: |
| Relationship to Policyholder: ☐ Self ☐ Child ☐ Spouse ☐ Other: _____ | | Policy Holder Name: (if not self): |
| | | Policy Holder D.O.B. (if not self): |

| For Workers Comp/Motor Vehicle Accident Claims ONLY | | |
|---|---|---|
| Claim #: | | Original Date of Injury/Onset: |
| Referring Physician: | | Diagnosis: |
| Motor Vehicle Related: ☐ Yes ☐ No | Work Related: ☐ Yes ☐ No | Adjuster Name: |
| | | Adjuster Phone: |
| | | Adjuster Fax: |

**If Workers Comp Claim:**

Was the accident with your current employer? ☐ Yes ☐ No

If "No", please specify the employer associated with this claim:

| Current Health Concerns |
|---|
| **Please list any current health complaints or concerns that bring you here today:** |
| |
| |
| |

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## Special Circumstances and Considerations

**Please indicate if any of the following conditions or circumstances pertain to you. Please note that checking any of these does not make you ineligible for treatment. However, it may restrict or affect some of your treatment modalities.**

| | | |
|---|---|---|
| Do you currently have or have you ever had Hepatitis? ☐ Yes ☐ No | Are you pregnant? ☐ Yes ☐ No | Are you taking blood-thinning medications? ☐ Yes ☐ No |
| Are you HIV positive? ☐ Yes ☐ No | Do you have a tendency to faint? ☐ Yes ☐ No | Do you have a pacemaker? ☐ Yes ☐ No |
| Have you ever experienced seizures? ☐ Yes ☐ No | Do you have high blood pressure? ☐ Yes ☐ No | Do you tend to bleed for a long time? ☐ Yes ☐ No |
| Do you have surgically implanted joint or bone replacements or stabilizers? ☐ Yes ☐ No | | |

## Family Medical History

**Check any of the following conditions blood relatives of yours currently have or have had in the past.**

☐ Alcoholism ☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Stroke
☐ Arteriosclerosis ☐ Cancer ☐ Heart Disease ☐ Seizures

☐ Allergies (please specify):

☐ Other (please specify):

## Past and Current Medical History

**Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.**

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Chicken Pox | ☐ Hepatitis | ☐ Pleurisy | ☐ Thyroid Disorders |
| ☐ Alcoholism | ☐ Diabetes | ☐ Herpes | ☐ Pneumonia | ☐ Tuberculosis |
| ☐ Appendicitis | ☐ Emphysema | ☐ High Blood Pressure | ☐ Polio | ☐ Typhoid Fever |
| ☐ Arteriosclerosis | ☐ Epilepsy | ☐ Measles | ☐ Rheumatic Fever | ☐ Ulcers |
| ☐ Asthma | ☐ Goiter | ☐ Multiple Sclerosis | ☐ Scarlet Fever | ☐ Venereal Disease |
| ☐ Birth Trauma (own birth) | ☐ Gout | ☐ Mumps | ☐ Seizures | ☐ Whooping Cough |
| ☐ Cancer | ☐ Heart Disease | ☐ Pacemaker | ☐ Stroke | |

☐ Allergies (please specify):

☐ Surgery (please specify):

☐ Major Physical or Emotional Trauma (please specify):

☐ Other (please specify):

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## Current Medications

**Please list all prescription medications you use. Include those you may only use occasionally (attach additional information if necessary):**

| Prescription Name | Purpose | Dosage | How Long | How Often | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Vitamins & Supplements

**Please list all vitamins and supplements you use. Include those you may only use occasionally:**

## Lifestyle Information

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Other Drugs
- ☐ Stress
- ☐ Occupational Hazards
- ☐ Regular Exercise (please specify):

## General Symptoms

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Prefer cold drinks
- ☐ Prefer hot drinks
- ☐ Recent weight loss/gain
- ☐ Poor Sleep
- ☐ Heavy sleep
- ☐ Dream disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Peculiar taste
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Shortness of breath
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Muscle cramps
- ☐ Vertigo or dizziness
- ☐ Bleed or bruise easily

## Head, Eyes, Ears, Nose and Throat Symptoms

- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Sinus problems
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Ear aches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Excessive phlegm

*Please describe color of phlegm:* _____

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## Respiratory Symptoms

- ☐ Difficulty breathing lying down
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Asthma/wheezing
- ☐ Wet Cough
- ☐ Dry Cough
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Thick phlegm
- ☐ Thin phlegm

## Cardiovascular Symptoms

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood Clots
- ☐ Fainting
- ☐ Chest pain / pressure
- ☐ Difficulty breathing
- ☐ Rapid/racing heartbeat
- ☐ Heart palpitations
- ☐ Phlebitis
- ☐ Irregular heartbeat

## Gastrointestinal Symptoms

- ☐ Nausea
- ☐ Constipation
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Itchy anus
- ☐ Black stools
- ☐ Bloating
- ☐ Intestinal pain or cramps
- ☐ Acid regurgitation
- ☐ Rectal pain
- ☐ Mucus in stool
- ☐ Anal fissures
- ☐ Laxative use
- ☐ Hiccup
- ☐ Bad breath
- ☐ Vomiting
- ☐ Burning anus
- ☐ Bloody stools

## Musculoskeletal Symptoms

- ☐ Limited range of motion
- ☐ Limited use
- ☐ Neck/shoulder pain
- ☐ Muscle pains
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Joint pain
- ☐ Rib pain
- ☐ Other: _____

## Skin and Hair Symptoms

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair Loss
- ☐ Change in hair or skin texture
- ☐ Fungal infections

☐ Other hair or skin problems (please specify):

## Neuropsychological Symptoms

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily stressed
- ☐ Abuse survivor
- ☐ Considered suicide
- ☐ Attempted suicide
- ☐ Seeing a therapist

☐ Other (please specify):

## Genito-urinary Symptoms

- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Incomplete urination
- ☐ Wake up to urinate
- ☐ Venereal disease
- ☐ Bedwetting
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Kidney stones
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission

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## Gynecological Symptoms

- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Painful periods
- ☐ Clots
- ☐ PMS
- ☐ PMDD
- ☐ Osteoporosis
- ☐ Lower back / sacrum ache
- ☐ Abnormal vaginal discharge
- ☐ Abnormal vaginal odor
- ☐ Vaginal sores
- ☐ Vaginal yeast infection
- ☐ Vaginal dryness
- ☐ Genital warts
- ☐ HPV+
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Polycystic ovary syndrome
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Uterine polyps
- ☐ Uterine myoma
- ☐ Swollen / painful breasts
- ☐ Breast lumps
- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Osteoporosis
- ☐ Night sweats / hot flashes
- ☐ Menopause / perimenopause

| | | |
|---|---|---|
| Age at which menses began: | Length of cycle: | Duration of flow: |

| | | | |
|---|---|---|---|
| # of pregnancies: | # of terminated pregnancies: | # of premature births: | # of miscarriages: |

| | | |
|---|---|---|
| Age at menopause: | Date of last PAP: | Date last period began: |

## Urological Symptoms

| | | | |
|---|---|---|---|
| ☐ Prostate problems<br>☐ Pain in testicles | ☐ Low sperm count / quality<br>☐ Loss of libido | ☐ Erectile dysfunction | ☐ Varicocele |

## Other Symptoms