ENHANCED WELLNESS *of* NEW MEXICO
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PATIENT GENERAL INFORMATION

PERSONAL

Patient name: .... Date: ....

Date of birth: .... Age: .... Height: .... Weight: .... Gender: ☐ M ☐ F

Marital status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Cohabitating

Occupation: .... ☐ Retired

Home address: ....

City: .... State: .... Zip: ....

Home phone: .... Cell phone: .... Work phone: ....

e-Mail address: .... May we contact you via email? ☐ Yes ☐ No

Emergency contact name: .... Phone: ....

Referred by: ....

Have you had acupuncture before? ☐ Yes ☐ No Chinese herbal medicine? ☐ Yes ☐ No

Your reason for visiting today: ....

....

Is your problem getting worse? ☐ Yes ☐ No Does it bother your: ☐ Sleep ☐ Work ☐ Other: ....

Have you been given a diagnosis for this problem? ☐ Yes ☐ No If yes, what? ....

Any other complaints? ....

....

Are you under the care of a physician now? ☐ Yes ☐ No If yes, for what: ....

Current medications: ....

....

Current vitamins/supplements: ....

....

MAJOR HOSPITALIZATIONS:

Please indicate if you have been hospitalized for any serious medical illness or operation:

Date: .... Operation/Illness: ....

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Date: .... Operation/Illness: ....

☐ Please check here if you have had more than 4 such hospitalizations, then use the back of the form to complete your hospitalization list.

PERSONAL *and* FAMILY HISTORY

Please complete for yourself and each family member by checkmarking the appropriate boxes.

	SELF	FATHER	MOTHER	BROTHER	SISTERS	CHILDREN
Allergies						
Asthma / Bronchitis						
Anemia / Blood disorder						
Cancer or tumors						
Diabetes						
Epilepsy / Seizures						
High blood pressure						
Kidney / Bladder disorder						
Drug or alcohol addiction						
Tobacco addiction						
Arthritis						
Heart disease / Heart disorder						
Stroke						
Thyroid disorder						
Skin disorder						
Hepatitis						
Kidney disorder						
Tuberculosis						
Musculo-Skeletal disorder						
Headaches / Migraine						
AIDS / HIV						
Arterioschlerosis						
Birth trauma						
COPD / Emphysema						
Herpes						
Ulcers						
Pacemaker						
Other family history:						

Patient name (please print): ....

Patient or guardian signature: .... Date: ....