DANIEL DIAMOND L.Ac., O.M.D.

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SANTA BARBARA, CA 93101

LICENSED ACUPUNCTURIST (LIC # AC 2233)

DOCTOR OF ORIENTAL MEDICINE

PATIENT HISTORY FORM

Name_______________________Date of Birth__________________Marital Status_________

Address____Soc. Sec. #_____________________
Street City Zip Code

Home Telephone________________________Work Telephone_______________________________

What is your occupation?____

Employer's name and address: ____

How were you referred to this office?____

Emergency Contact: Name______________________________Telephone______________________

Insurance Company______________________Policy Number____________________Group Number____________

Telephone_____________________Address____

Is there a lawsuit pending from injury or accident?_______ If yes, when was the accident, and what is the name and phone number of your attorney?____

Who is your current primary physician?____

What is your medical diagnosis?____

Who provided the diagnosis?___________________________________When?______________

Purposes for seeking Acupuncture therapy____

____

I certify that the above statements are true.
I authorize the release of medical information and payment for health insurance claims.

Signature____Date_______________________

NUTRITION: Please circle or list the foods in your usual diet.
Protein: beef pork chicken turkey beans tofu fish nuts drinks eggs other:_______________
Grains: rice wheat oats other:_________________ *Fruits:*_______________________________________
*Raw vegetables:*______________________________*Cooked vegetables:*______________________________
Dairy: milk cheese yogurt cottage cheese *Desserts:*____
*Fast foods:*____ *Fats and oils:*_____________________________
*Favorite spices, flavor cravings:*____
*Foods which create problems for you:*____

How frequently do you use: soft drinks__________coffee____________alcohol___________cigarettes___________

What dietary supplements (vitamins, minerals, herbs, etc.) do you take?_____________________________________
____

What prescribed medications do you take?____

Past long-term medications?____

Surgical history:____

Contagious disease history (herpes, hepatitis, HIV, etc.):____

What type of exercise do you regularly perform?____

Do you often experience anxiety, depression, irritability or mood swings? ____________________________

Circle any climate you prefer and cross out any conditions that you dislike: cold damp hot dry wind

FAMILY MEDICAL HISTORY (Circle conditions)

arthritis diabetes heart disease asthma epilepsy cancer hormone problems
psychological disorders other:____

FEMALES

Are you or might you be pregnant?________ If yes, what month?________ Birth control method?________________
Abnormal PAP test?________When?__________Number of children____________Miscarraiges?_______________
Do you have any menstrual problems? (irregularity, pain, PMS, discharges, etc.)_______________________________
____
How long does your period last?_________Time between periods?__________Excess or lack of flow?____________

Are you peri- or post-menopausal?_________Menopausal problems? _______________________________________

Other gynecological problems?____

MALES

Reduced libido?___________Sperm irregularities?_________________Genital or scrotal pain?_________________

Other problems or issues?____