Southern Village Acupuncture and Herbology
410 Market Street #330
Chapel Hill, NC 27516
919-590-9870

Patient General Information

Name:_____ **中文名字：** _____
(first) (middle) (last)

Date of Birth:____/____/_____ **Gender:** _____
(mo) (day) (year)

Occupation: _____

Address:_____(street, apt) **Phone #:** _____

_____(city, state, zip code)

Email: _____

Emergency Contact: _____ **Phone #:** _____

How did you hear about us? _____

Reasons for visit, in the order of significance to you:

1._____

2._____

3._____

4._____

Signature:_____ **Date:**_____

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Patient Consent Form

I, _____, hereby consent to be treated with acupuncture and herbal medicine by Li Lin at Southern Village Acupuncture and Herbology LLC.

I understand that acupuncture is performed by the insertion of fine needles into specific points of the body with the intent of improving body functions and/or relieving pain.

I understand that only pre-sterilized, disposable needles will be used.

I understand that the needles may cause some temporary localized pain, bruising, or light headaches.

I understand that heat or cupping therapy may also be used and natural herbal formula may be prescribed.

I accept the fact that there is no guarantee concerning the outcome of my acupuncture or herbal treatments and I understand that I may stop treatment at any time. I also accept that there are no refunds on any services, including herbal formula.

I understand payment must be made in full at the time of service.

Signature of Patient or Guardian:_____ Date: _____

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Medical History

- please check any following conditions you have had with X

___Allergies	___Diabetes	___HIV	___Multiple Sclerosis
___Asthma	___Emphysema	___Heart attack	___Seizure
___Bleeding tendency	___Epilepsy	___Hepatitis	___Stroke
___Cancer	___Glaucoma	___Hypertension	___Tuberculosis

___Other conditions not listed above, please explicit:_____

- Have you ever had any surgery?_____ If yes, please list type and year below:

_____
_____
_____
_____

- Are you taking any medication currently? _____ If yes, please list your medications:

_____
_____
_____

- Are you taking any supplements currently? _____ If yes, please list your supplements:

_____
_____
_____

- Do you have allergy? _____ If yes, please list your allergens:

_____
_____
_____

- Do you have pacemaker installed? _____

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Current Health Conditions

Please check the following conditions that **currently** pertain to you with X, explicit if necessary.

- Sleep:

___*good*
___*intermittent*
___*difficult falling asleep*
___*light sleep*
___*cannot sleep at all*
___*lots of dream*
___*feel rested upon waking up*
___*feel tired upon waking up*

- Appetite:

___*good;*
___*excessive*
___*fair*
___*poor*
___*no appetite at all*
___*picky eater*
___*comfort eating*
____*food craving (craving for_____)*

- Thirst:

___*normal*
___*excessive*
___*no thirst*
___*thirsty but don't want to to drink*

- Preferable temperature of drinks:

___*hot*
___*warm*
___*room temperature*
___*cool*
___*cold*
___*icy*

- Bowel movement:

___*time(s)/day*
___*normal*
___*constipation*
___*diarrhea*
___*urgent*
___*abdominal cramping*

- Consistency of stool:

___*hard*
___*soft*
___*loose*
___*watery*
___*small pellets*
___*bloody*
___*mucous*

- Urination:

___*time(s)/day*
___*time(s)/night*
___*strong*
___*weak*
___*incontinent*
___*painful*
___*burning*
___*no urine desire*

- Urine color:

___*light yellow*
___*medium yellow*
___*dark yellow*
___*pink*
___*red*

- Other info about urine:

____*clear* ___*cloudy* ___*bubbles* ___*strong odor*

- Perspiration:

___*difficult*
___*normal*
___*easy*
___*spontaneous sweat*
___*night sweat*
___*hot flashes*

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Current Health Conditions

- Hands:

___*hot*
___*warm*
___*cool*
___*cold*
___*swollen*
___*numb*
___*pain*
___*tingling*
___*burning*
___*discolored*

- Feet:

___*hot*
___*warm*
___*cool*
___*cold*
___*swollen*
___*numb*
___*pain*
___*tingling*
___*burning*
___*discolored*

- Body:

___*hot*
___*warm*
___*cool*
___*cold*
___*alternately cold and hot*

- Energy:

___*good*
___*fair*
___*poor*
___*tired in the morning*
___*tired in the afternoon*

- Emotion:

___*stressful*
___*irritable*
___*anxious*
___*depressed*
___*panic*
___*sorrow*
___*happy*
___*worrisome*
___*sad*

- Skin

___itchy
___burning
___flaky
___painful
___inflamed
___acne
___rash
___hives
___ulcer

- Other symptoms and conditions:

___*acid reflux*
___*abdominal pain*
___*abdominal bloating*
___*chest pain*
___*chest congestion*
___*cough*
___*dizziness*
___*ear ringing*
___*heartburn*
___*headache*
___*light headed*
___*nasal congestion*
___*nausea*
___*palpitation*
___*shortness of breath*
___*stomach pain*
___*vomiting*
___*conditions not listed above, please explicit:* _____

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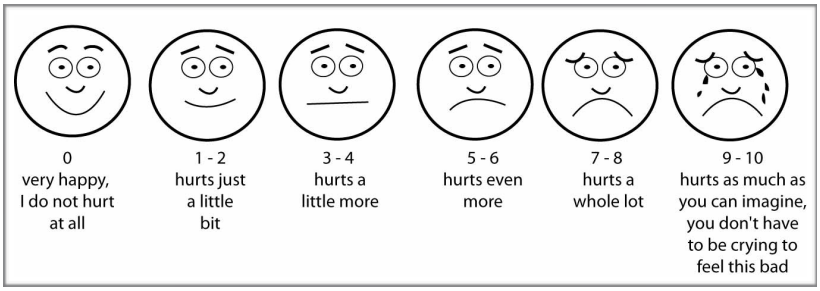
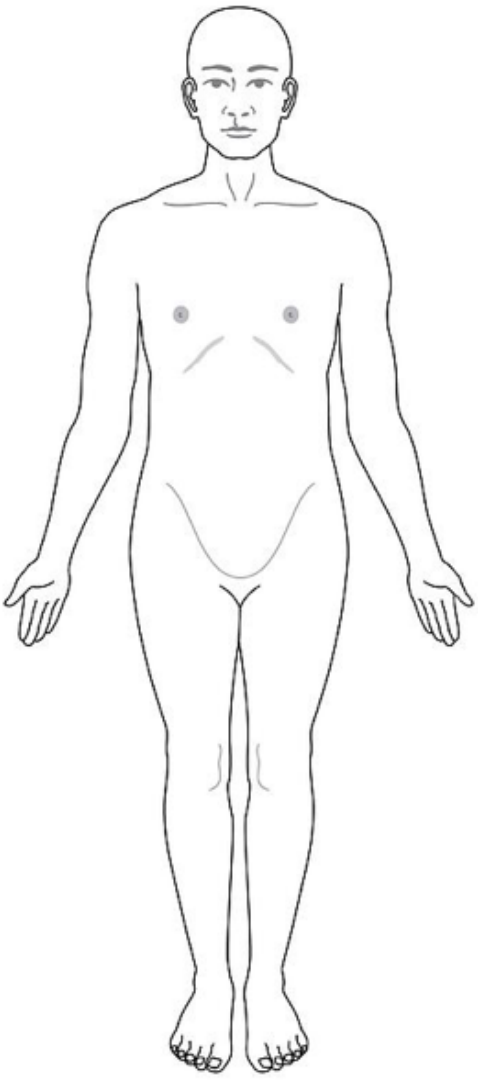
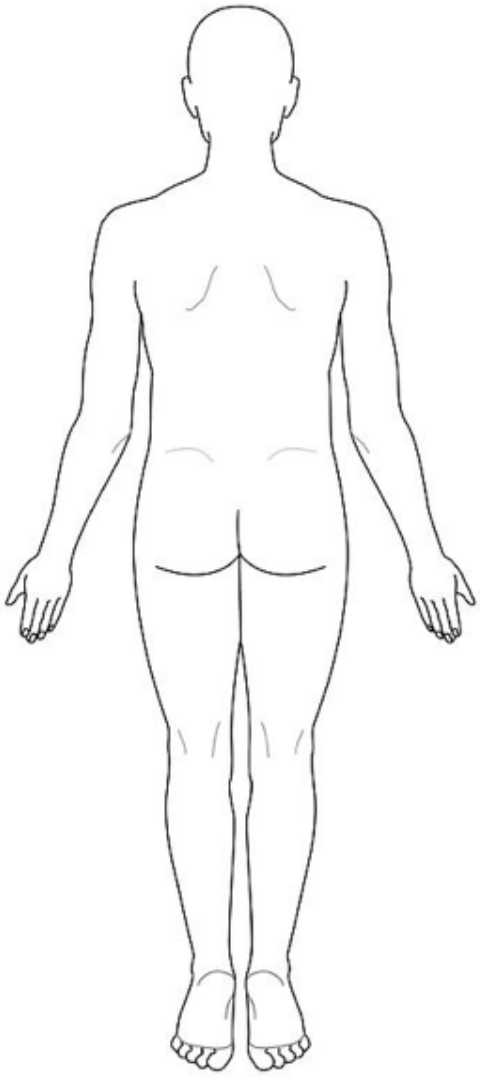
Pain:

Please mark the area that you are experiencing pain, and write down the pain level referring to the pain scale to the right.







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For Women Only - Gynecological Conditions

- Check any following conditions **currently** applicable to you

___Endometriosis
___Blocked Fallopian tube
___Infertility
___Menopause
___Ovarian cyst
___PMS
___Peri-Menopause
___Polycystic Ovarian Syndrome
___Pelvic Inflammatory Disease
___Recurrent miscarriages
___STD
___Uterine fibroids
___Yeast infection
___Breast cancer
___Cervical cancer
___Ovarian cancer
___Uterine cancer
___Hysterectomy

- Menstruation

___regular
___irregular
___no menses

How frequent is your menstrual cycle? Every ____ days.
How long does your menstrual cycle last? ____ days.
When was the 1st day of your last menses? _____

- Before menstrual cycle

___abdominal bloating
___abdominal cramping
___acne breakout
___breast tenderness
___craving for sweets
___depressed
___diarrhea
___headache
___irritable
___insomnia
___lower back pain
___night sweat

- On menstrual cycle

___abdominal bloating
___abdominal cramping
___breast tenderness
___diarrhea
___fatigue
___fever
___headache
___moody
___insomnia
___lower back pain
___night sweat
___nosebleed
___swelling
___vomiting

- After menstrual cycle

___abdominal cramping
___breast tenderness
___dizzy
___fatigue
___headache
___insomnia
___night sweat
___spotting

- During ovulation (usually 2 weeks before menstrual cycle)

___no ovulation
___abdominal pain
___bleeding
___no/little mucus
___moderate mucus
___excessive mucus
___clear mucus
___yellow mucus
___green mucus
___brown mucus