PERSONAL INFORMATION FORM

CHINESE MEDICINE PRACTICE OF DONALD LONDORF, MD, L.AC., PC
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Today's Date ____/____/____ (M/D/Y)

1. GENERAL INFORMATION

Last Name _____ First Name _____
Date of Birth ____/____/____ (M/D/Y) Age ____ Height _____ Weight _____
Address _____ (Street Address)
_____ (City, State, Zip)
Telephone Home _____ Cellular _____
Work _____ Email _____
Occupation _____
Circle one: Single Married Separated Divorced Widowed
Where did you hear about this office? _____
Name, address and telephone number of your primary care physician

_____
Name and telephone no. of person to contact in case of emergency

_____

2. COMPLEMENTARY-ALTERNATIVE CARE

Have you ever received acupuncture , Chinese herbs or qigong? (Circle which one)
When and by which practitioner? _____

Do you presently see any other complementary-alternative care practitioners? yes ❑ no ❑
Which one(s) ? _____

3. REASON FOR VISIT

What issue(s) do you wish to address with Chinese medicine?

_____

When did you first notice symptoms? _____

To what extent does this issue affect your daily activities? _____

What diagnosis have you been given by your physician? _____

What kind of treatment(s) have you received so far? _____

4. MEDICAL INFORMATION

Please list all previous and current medical problems: (include dates)

_____

_____

_____

Please list all previous surgeries:

_____

_____

Please list all previous and current psychiatric/psychological problems: (include dates)

_____

_____

Have you ever had or tested positive for: ❑ Hepatitis? ❑ HIV or AIDS?

Do you: ❑ take anticoagulants? ❑ take blood thinners? ❑ bruise easily?

Please list any illnesses that run in your family?

_____

Please list any allergies you may have to:

Medication(s) _____

Herbs/supplements _____

Food(s) _____

The environment _____

Please list all the medications, herbs, or supplements you take. (include doses and frequency)

_____

_____

_____

Do you:	smoke?	yes ❑	no ❑	drink coffee/tea/cola?	yes ❑	no ❑
	drink alcohol?	yes ❑	no ❑	use mind altering drugs?	yes ❑	no ❑
	exercise regularly?	yes ❑	no ❑	drink water every day?	yes ❑	no ❑

Diet: (circle the items below that are a regular part of your diet)

vegetables fruits grains nuts fish poultry red meat low fat low salt

chocolate dessert fast food fried food

List the top three sources of stress in your life? _____

What do you do to decrease your stress level? _____

5. SYNDROME ASSESSMENT (PROVIDE AS MANY DETAILS AS POSSIBLE)

General

Energy level ❑ high ❑normal ❑ low
❑ Fatigue/tiredness
❑ Fever
❑ Chills
❑ Usually feel hot
❑ Usually feel cold
❑ Usually feel dry
Sweating ❑ none
❑ frequent/daytime
❑ night time
❑ Thirst ❑ preference for hot fluids
❑ preference for cold fluids

Weight ❑ gain ❑ loss ❑ stable
❑ Heat sensation in chest, palms or soles
❑ Cold hands/feet
❑ Frequent colds/infections
❑ Swollen lymph nodes/glands
where? _____
❑ Body feels heavy
❑ Bruise/bleed easily
❑ Greying ❑ falling or ❑ lifeless hair
❑ Skin problem
specify _____
❑ Dislike for wind
❑ Dislike for cold

❑ Dislike for heat
❑ Dislike for humidity
❑ Symptoms worse with exertion
❑ Symptoms worse with emotions/stress
❑ Symptoms worse at particular time of day

Sleep
❑ difficulty falling asleep
❑ frequent awakening
❑ wake up at same time ___ am
❑ worse with stress
❑ disturbing dreams
❑ busy mind
❑ palpitations/anxiety

Eyes, Ears, Nose, Throat & Respiratory

❑ Blurred vision
❑ Dry eyes
❑ Red/congested eyes
❑ Darkness under eyes
❑ Ear ache
❑ Loss of hearing
❑ Ringing in the ears
sounds like _____
❑ Dizziness
❑ Vertigo
❑ Nasal congestion
❑ Reduction or loss of smell

❑ Nasal discharge
❑ watery/clear ❑ thick ❑ white
❑ yellow ❑ green ❑ bloody
❑ Nose bleeds
❑ Sneezing
❑ Frequent sighing
❑ Sinus pain where? _____
❑ Dry mouth
❑ Mouth/tongue ulcers/sores
❑ Sore throat
❑ Recurrent sore throat and swollen neck glands

❑ Loss of voice/hoarseness
❑ better with rest
Worse:
❑ in afternoon ❑ in morning
❑ with emotions ❑ with overuse
❑ Cough ❑ dry ❑ productive
❑ Sputum ❑ watery/clear ❑ sticky
❑ thick ❑ white
❑ yellow ❑ green ❑ bloody
❑ Shortness of breath
❑ with exertion ❑ at rest
❑ lying down ❑ wheezing

Cardiovascular

Blood pressure
❑ high ❑ normal ❑ low
❑ Facial flushing
❑ Hot flashes
❑ Pale lips and nails
❑ Finger or toe discoloration
❑ Swelling
where? _____

❑ Palpitation frequency? _____
duration? _____
timing? _____
❑ Tight feeling in chest
❑ Chest pain/discomfort
location? _____
worse with? _____
better with? _____

❑ Chest pain/discomfort
sensation
❑ stuffy ❑ full
❑ discomfort ❑ squeezing
❑ weight-like ❑ burning
❑ sharp/stabbing
frequency? _____
duration? _____

Genito-Urinary

Urine ❑ clear ❑ concentrated/dark
❑ cloudy ❑ bloody
❑ Frequent urination ❑ day ❑ night
❑ Urgent urination

❑ Pain with urination ❑ during ❑ before ❑ after
❑ Difficulty urinating
❑ Retention of urine
❑ Dribbling or incontinence

❑ Discharge
❑ Genital herpes ❑ HPV
Libido ❑ increased ❑ decreased
❑ Sexual dysfunction

Gastrointestinal

Appetite ❑ strong ❑ normal ❑ weak
❑ Toothache
❑ Teeth grinding
❑ TMJ
❑ Bleeding gums
❑ Bitter taste in mouth
❑ Bad breath
❑ Frequent belching
❑ Excessive gas
❑ Nausea
❑ Acid regurgitation

❑ Vomiting ❑ undigested food ❑ bile ❑ blood
❑ Difficulty swallowing
❑ Bloating
Bowel movements
Frequency _____
❑ loose stool/diarrhea ❑ constipated/dry stools
❑ mucus
❑ undigested food ❑ bloody/ black stools
❑ Burning/itching anus or rectum
❑ Hemorrhoids

❑ Abdominal pain
location _____
❑ worse with pressing
❑ better with pressing
factors that increase it _____
factors that decrease it _____
sensation? _____
frequency? _____
duration? _____

Musculoskeletal

❑ Headache
where? _____
feels like _____
how often ? _____
duration ? _____

❑ Muscle aches/stiffness
where? _____

❑ Joint aches/stiffness
where? _____
❑ Cramp/spasm
where? _____
❑ Tendonitis
where? _____

❑ Low back ache
❑ fixed location ❑ vague
❑ changes location ❑ dull
❑ sharp ❑ stabbing
❑ worse with cold/wet
❑ worse with movement
❑ worse in morning
❑ worse with emotional upset or stress
❑ worse after sex ❑ not weather related
❑ back of knees feels weak

Nervous System

❑ Irritability/restlessness
❑ Easy to anger
❑ Anxiety
❑ Easily stressed
❑ Depression

❑ Poor concentration or memory
❑ Forgetfulness
❑ Loss of balance/coordination
❑ Numbness/sensory changes
location _____

❑ Motor weakness
location _____
❑ Difficulty with speech
❑ Seizures
❑ Sleepiness during the day

Gynecology & Obstetric

Date of last normal menses _____
Length of cycle (day 1 to day 1) _____
Duration of menstrual flow _____
Age menses began _____
❑ Menstrual cramping
❑ Excessive bleeding
❑ Spotting
❑ Clots

❑ Irregular periods
❑PMS ❑ breast tenderness ❑ mood change
❑ swelling ❑ other _____
❑ Breast lumps
❑ Ovarian cysts
❑ Uterine fibroids
❑ Endometriosis
Age at menopause _____

❑ Vaginal discharge

Full term pregnancies _____
Premature births _____
Miscarriages _____
Early termination _____

Living children _____

Other Concerns or Comments

_____

_____

What Do You Expect To Achieve? _____

How Long Do You Think It Will Take For You To Heal? _____