



Flowing River Clinic

COMPLEMENTARY ALTERNATIVE MEDICINE

Phone: 510.893.2929 • Fax: 510.893.2928 • 2929 Summit Street, Suite 102, Oakland, CA 94609

PERSONAL INFORMATION

PATIENT NAME: LAST		FIRST	MIDDLE
ADDRESS/CITY/STATE/ZIP CODE:			
TEL.:	HOME ()	MOBILE ()	WORK ()
EMAIL:		SOCIAL SECURITY NO.:	
DATE OF BIRTH:	AGE:	GENDER:	HEIGHT: WEIGHT:
EMERGENCY CONTACT:	TEL.:	RELATIONSHIP:	
REFERRED BY:			
STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED NAME:			

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> STUDENT				
EMPLOYER/SCHOOL NAME:		EMPLOYER/SCHOOL TEL: ()		
EMPLOYER/SCHOOL ADDRESS:				

PRIMARY HEALTHCARE PROVIDER

PRIMARY PHYSICIAN:	TEL.:	
	()	
PHYSICIAN ADDRESS:		
DATE OF LAST VISIT:	REASON:	DATE OF INJURY/ONSET OF ILLNESS:

INSURANCE / SUPERBILL INFORMATION

INSURANCE COMPANY:	POLICY HOLDER'S NAME:
POLICY NAME (IF APPLICABLE):	EMPLOYER NAME (IF APPLICABLE):
POLICY NO.:	GROUP NO.:
INSURANCE COMPANY TEL.:	INSURANCE COMPANY FAX.:
()	()



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ILLNESS AND TREATMENT INFORMATION

WHAT HEALTH ISSUE DO YOU WANT TREATED? PLEASE DESCRIBE AS FULLY AS POSSIBLE.

ARE YOU PRESENTLY BEING TREATED FOR THIS CONDITION? PLEASE DESCRIBE.
 NO YES

HAVE YOU BEEN USING OTHER TREATMENTS FOR RELIEF OF THIS ISSUE? PLEASE DESCRIBE.
 NO YES

DO YOU HAVE OTHER HEALTH CONCERNS? PLEASE DESCRIBE.
 NO YES

ARE YOU PRESENTLY BEING TREATED FOR ANY OTHER MEDICAL CONDITION? PLEASE DESCRIBE.
 NO YES

HAVE YOU EVER HAD AN ACUPUNCTURE TREATMENT? WHEN AND FOR WHAT REASON?
 NO YES

FAMILY HISTORY INFORMATION (PLEASE COMPLETE FOR EACH FAMILY MEMBER, PLACING AN X IN THE APPROPRIATE BOX):

	SELF	MOTHER	FATHER	SISTER	BROTHER	SPOUSE	CHILD
ASTHMA							
ALLERGIES							
BLOOD DISORDER/ANEMIA							
DIABETES							
CANCER OR TUMORS							
SEIZURES							
HIGH BLOOD PRESSURE							
THYROID DISORDER							
KIDNEY OR BLADDER DISORDER							
STOMACH OR INTESTINAL DISORDER							
SUBSTANCE ABUSE							
TUBERCULOSIS							
HEART DISEASE							
STROKE							
DEPRESSION/ANXIETY							
MENTAL ILLNESS							
HIV/AIDS							
HEPATITIS							
OTHER							
AGE OF DEATH	X						



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MAJOR HOSPITALIZATIONS (WRITE IN ANY RECENT HOSPITALIZATIONS FOR SERIOUS INJURY OR ILLNESS):

YEAR OPERATION OR ILLNESS NAME OF HOSPITAL CITY AND STATE
YEAR OPERATION OR ILLNESS NAME OF HOSPITAL CITY AND STATE

SIGNIFICANT TRAUMAS (STRAINS/TEARS/FALLS). PLEASE DESCRIBE:

YEAR	TYPE
YEAR	TYPE

OCCUPATIONAL STRESS (PHYSICAL/PSYCHOLOGICAL/CHEMICAL). PLEASE DESCRIBE:

YEAR	TYPE
YEAR	TYPE

PREGNANCIES:

ARE YOU PREGNANT NOW? <input type="checkbox"/> NO <input type="checkbox"/> YES	DO YOU PRACTICE BIRTH CONTROL? <input type="checkbox"/> NO <input type="checkbox"/> YES			
WHAT TYPE OF BIRTH CONTROL?	HOW LONG ON BIRTH CONTROL?			
TOTAL PREGNANCIES:	BIRTHS	ECTOPIC	MISCARRIAGES	INDUCED ABORTIONS

MENSES

AGE OF FIRST MENSES:	AGE OF MENOPAUSE:
HOW MANY DAYS IS YOUR PERIOD? _____ DAYS	NUMBER OF DAYS BETWEEN PERIODS? _____ DAYS
FIRST DAY OF YOUR LAST PERIOD: ____/____/____	DATE OF LAST PAP SMEAR: ____/____/____ <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL

MEDICINES (PLEASE LIST ALL MEDICINES/VITAMINS/HERBS WITH DOSAGES ON BACK OF THIS PAGE):

<input type="checkbox"/> ASPIRIN <input type="checkbox"/> IBUPROFEN <input type="checkbox"/> ACETAMINOPHEN (TYLENOL) <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> ANTACIDS <input type="checkbox"/> LAXATIVES
<input type="checkbox"/> COLD TABLETS <input type="checkbox"/> VITAMINS: _____ <input type="checkbox"/> ORAL CONTRACEPTIVES <input type="checkbox"/> DIET PILLS <input type="checkbox"/> FIBER SUPPLEMENTS
<input type="checkbox"/> ANTI-DEPRESSANTS _____ <input type="checkbox"/> SLEEPING PILLS <input type="checkbox"/> HAY FEVER TABLETS <input type="checkbox"/> HERBS: _____
<input type="checkbox"/> BLOOD PRESSURE PILLS <input type="checkbox"/> BLOOD THINNING PILLS <input type="checkbox"/> INSULIN, DIABETIC PILLS _____

ALLERGIES (DRUG/CHEMICAL/FOOD/ANIMAL/PLANT). PLEASE LIST:

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PLEASE LIST ALL MEDICINES, VITAMINS, SUPPLEMENTS, AND HERBS

NAME	DOSAGE PER DAY
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____
16. _____	_____
17. _____	_____
18. _____	_____
19. _____	_____
20. _____	_____



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HABITS (PLEASE CHECK ANY OF THE HABITS LISTED BELOW WHICH APPLY TO YOU NOW OR IN THE PAST):

COFFEE: [] NO [] YES	CUPS PER DAY/WEEK	AGE STARTED	AGE QUIT
TOBACCO: [] NO [] YES	CIGARETTES PER DAY/WEEK	AGE STARTED	AGE QUIT
ALCOHOL: [] NO [] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
MARIJUANA: [] NO [] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
COCAINE: [] NO [] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
HEROINE: [] NO [] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
OTHER: _____	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
OTHER: _____	USE PER DAY/WEEK	AGE STARTED	AGE QUIT

EXERCISE:

[] WALK	NUMBER OF DAYS/WEEK: _____	DISTANCE: _____	LENGTH OF WALK: _____
[] JOG	NUMBER OF DAYS/WEEK: _____	DISTANCE: _____	LENGTH OF JOG: _____
[] RUN	NUMBER OF DAYS/WEEK: _____	DISTANCE: _____	LENGTH OF RUN: _____
[] STRENGTH TRAINING	# OF DAYS/WEEK: _____	LENGTH OF SESSION: _____	
[] SWIMMING	# OF DAYS /WEEK: _____	LENGTH OF SESSION: _____	
[] TREADMILL/ELLIPTICAL	# OF DAYS /WEEK: _____	LENGTH OF SESSION: _____	
[] YOGA / TAI CHI/QI GONG	# OF DAYS /WEEK: _____	LENGTH OF SESSION: _____	
[] MARTIAL ARTS	# OF DAYS /WEEK: _____	LENGTH OF SESSION: _____	TYPE: _____
[] OTHER: _____	# OF DAYS/WEEK: _____	LENGTH OF SESSION: _____	

DIET (PLEASE LIST WHEN AND WHAT YOU EAT FOR BREAKFAST/LUNCH/DINNER/SNACKS):

6AM - 10AM
10AM - 12 NOON
12 NOON - 2PM
2PM - 5PM
5PM - 7PM
7PM - 12 MIDNIGHT



HEALTH (CHECK ALL THAT APPLY):

GENERAL

PAST CURRENT

- FATIGUE
- CATCH COLD EASILY
- RECURRENT INFECTIONS
- BLEED OR BRUISE EASILY
- POOR APPETITE
- EXCESSIVE APPETITE
- CHANGE IN APPETITE
- WEIGHT GAIN
- WEIGHT LOSS
- FREQUENT FEVERS
- CHRONIC LOW GRADE FEVER
- HOT HANDS, CHEST, OR FEET
- NIGHT SWEATS
- SWEAT EASILY
- CHILLS
- COLD HANDS OR FEET
- LOCALIZED WEAKNESS
- POOR COORDINATION
- STRONG THIRST
- THIRST WITH NO DESIRE TO DRINK
- DRY MOUTH
- FOOD CRAVINGS
- OTHER: _____

ENERGY LEVEL

- LOW (TIME OF DAY) _____
- HIGH (TIME OF DAY) _____
- SUDDEN FLUCUATIONS
- SLEEPY AFTER EATING

SLEEP

- INSOMNIA
- DIFFICULT FALLING ASLEEP
- DIFFICULT STAYING ASLEEP
- WAKES NIGHTLY AT SAME TIME _____
- WAKES TOO EARLY AT SAME TIME _____
- RESTLESS SLEEP/DREAM DISTURBED
- VIVID DREAMS
- NIGHTMARES
- GRINDING TEETH
- SLEEPWALKING
- SNORING/SLEEP APNEA
- HOURS OF SLEEP A NIGHT _____

SKIN & HAIR

- RASHES
- HIVES
- ITCHING
- ECZEMA
- PSORIASIS
- PIMPLES
- TUMORS/LUMPS
- WARTS
- CHANGING MOLES
- DRY SKIN/SCALP/HAIR
- HAIR LOSS
- OTHER: _____

HEAD & NECK

PAST CURRENT

- DIZZINESS/VERTIGO
- FAINTING
- NECK STIFFNESS
- ENLARGED LYMPH GLANDS
- FREQUENT HEADACHES
- MIGRAINES
- BELLS PALSY
- TMJ
- CONCUSSION/HEAD TRAUMA
- OTHER: _____

EARS

- INFECTION
- RINGING
- DECREASED HEARING
- OTHER: _____

EYES

- BLURRED VISION
- VISUAL CHANGES
- POOR NIGHT VISION
- SPOTS
- CATARACTS
- GLASSES / CONTACTS
- EYE INFLAMMATION
- DRY EYES
- OTHER: _____

NOSE, THROAT, MOUTH

- NOSE BLEEDS
- SINUS INFECTIONS
- HAY FEVER OR ALLERGIES
- RECURRING SORE THROATS
- TEETH/GUM/TONGUE PROBLEMS
- DIFFICULTY SWALLOWING
- OTHER: _____

CARDIOVASCULAR

- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- BLOOD CLOTS
- PALPITATIONS
- FAINTING
- PHLEBITIS
- CHEST PAIN
- IRREGULAR HEART BEAT
- PACEMAKER
- VARICOSE/SPIDER VEINS
- COLD HANDS / FEET
- SWELLING OF HANDS / FEET
- OTHER: _____



HEALTH, CONTINUED

RESPIRATORY

- | PAST | CURRENT | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | ASTHMA/WHEEZING |
| <input type="checkbox"/> | <input type="checkbox"/> | DIFFICULT OR PAINFUL BREATHING |
| <input type="checkbox"/> | <input type="checkbox"/> | SHORTNESS OF BREATH |
| <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT COLDS |
| <input type="checkbox"/> | <input type="checkbox"/> | BRONCHITIS |
| <input type="checkbox"/> | <input type="checkbox"/> | PNEUMONIA |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD/EMPHYSEMA |
| <input type="checkbox"/> | <input type="checkbox"/> | PERSISTENT COUGH |
| <input type="checkbox"/> | <input type="checkbox"/> | DRY COUGH |
| <input type="checkbox"/> | <input type="checkbox"/> | COUGHING BLOOD |
| <input type="checkbox"/> | <input type="checkbox"/> | PRODUCTION OF PHLEGM |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ |

GASTRO-INTESTINAL

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HEARTBURN/GERD |
| <input type="checkbox"/> | <input type="checkbox"/> | INDIGESTION/BLOATING |
| <input type="checkbox"/> | <input type="checkbox"/> | NAUSEA |
| <input type="checkbox"/> | <input type="checkbox"/> | VOMITING |
| <input type="checkbox"/> | <input type="checkbox"/> | BELCHING |
| <input type="checkbox"/> | <input type="checkbox"/> | BAD BREATH |
| <input type="checkbox"/> | <input type="checkbox"/> | DIARRHEA |
| <input type="checkbox"/> | <input type="checkbox"/> | CONSTIPATION |
| <input type="checkbox"/> | <input type="checkbox"/> | PAIN OR CRAMPS |
| <input type="checkbox"/> | <input type="checkbox"/> | HEMORRHOIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | RECTAL PAIN |
| <input type="checkbox"/> | <input type="checkbox"/> | BLOODY STOOLS |
| <input type="checkbox"/> | <input type="checkbox"/> | UNDIGESTED FOOD IN STOOL |
| <input type="checkbox"/> | <input type="checkbox"/> | GALL BLADDER DISORDER |
| <input type="checkbox"/> | <input type="checkbox"/> | GAS/FLATULENCE |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: ___ |

GENITO-URINARY

- | | | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT URINARY TRACT INFECTIONS |
| <input type="checkbox"/> | <input type="checkbox"/> | KIDNEY STONES |
| <input type="checkbox"/> | <input type="checkbox"/> | PAIN ON URINATION |
| <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT URINATION |
| <input type="checkbox"/> | <input type="checkbox"/> | URGENCY TO URINATE |
| <input type="checkbox"/> | <input type="checkbox"/> | UNABLE TO HOLD URINE |
| <input type="checkbox"/> | <input type="checkbox"/> | BLOOD IN URINE |
| <input type="checkbox"/> | <input type="checkbox"/> | CLOUDY URINE |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ |

MALE

- | | | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | PAIN / ITCHING GENITALIA |
| <input type="checkbox"/> | <input type="checkbox"/> | GENITAL LESIONS / DISCHARGE |
| <input type="checkbox"/> | <input type="checkbox"/> | IMPOTENCE |
| <input type="checkbox"/> | <input type="checkbox"/> | WEAK URINARY STREAM |
| <input type="checkbox"/> | <input type="checkbox"/> | LUMPS IN TESTICLES |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ |

FEMALE

- | PAST | CURRENT | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | FREQUENT VAGINAL INFECTIONS |
| <input type="checkbox"/> | <input type="checkbox"/> | PAIN / ITCHING OF GENITALIA |
| <input type="checkbox"/> | <input type="checkbox"/> | GENITAL LESIONS / DISCHARGE |
| <input type="checkbox"/> | <input type="checkbox"/> | PELVIC INFLAMMATORY DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | ABNORMAL PAP SMEAR |
| <input type="checkbox"/> | <input type="checkbox"/> | IRREGULAR MENSTRUAL PERIODS |
| <input type="checkbox"/> | <input type="checkbox"/> | PAINFUL MENSTRUAL PERIODS |
| <input type="checkbox"/> | <input type="checkbox"/> | PREMENSTRUAL SYNDROME |
| <input type="checkbox"/> | <input type="checkbox"/> | ABNORMAL BLEEDING |
| <input type="checkbox"/> | <input type="checkbox"/> | FIBROIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | INFERTILITY |
| <input type="checkbox"/> | <input type="checkbox"/> | MENOPAUSAL SYNDROME |
| <input type="checkbox"/> | <input type="checkbox"/> | BREAST LUMPS |
| <input type="checkbox"/> | <input type="checkbox"/> | NIPPLE DISCHARGE |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ |

NEUROLOGICAL

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | SEIZURES |
| <input type="checkbox"/> | <input type="checkbox"/> | TREMORS |
| <input type="checkbox"/> | <input type="checkbox"/> | NUMBNESS/TINGLING OF LIMBS |
| <input type="checkbox"/> | <input type="checkbox"/> | PARALYSIS |
| <input type="checkbox"/> | <input type="checkbox"/> | PERIPHERAL NEUROPATHY |
| <input type="checkbox"/> | <input type="checkbox"/> | PARKINSON'S DISEASE |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ |

PSYCHOLOGICAL

- | | | |
|--------------------------|--------------------------|-------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | DEPRESSION |
| <input type="checkbox"/> | <input type="checkbox"/> | ANXIETY |
| <input type="checkbox"/> | <input type="checkbox"/> | IRRITABILITY/ STRESS |
| <input type="checkbox"/> | <input type="checkbox"/> | TREATED FOR EMOTIONAL OR PSYCHOLOGICAL PROBLEMS |
| <input type="checkbox"/> | <input type="checkbox"/> | OTHER: _____ |

INFECTION SCREENING

- | | | |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | TB |
| <input type="checkbox"/> | <input type="checkbox"/> | HEPATITIS |
| <input type="checkbox"/> | <input type="checkbox"/> | GONORRHEA |
| <input type="checkbox"/> | <input type="checkbox"/> | CHLAMYDIA |
| <input type="checkbox"/> | <input type="checkbox"/> | SYPHILIS |
| <input type="checkbox"/> | <input type="checkbox"/> | GENITAL WARTS |
| <input type="checkbox"/> | <input type="checkbox"/> | HERPES: ORAL |
| <input type="checkbox"/> | <input type="checkbox"/> | HERPES: GENITAL |



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PAIN

DO YOU HAVE ANY BODY PAIN? PLEASE DESCRIBE AS FULLY AS POSSIBLE. <input type="checkbox"/> ACUTE <input type="checkbox"/> CHRONIC				
DATE OF ONSET: HOW LONG HAVE YOU HAD THE PAIN?				
IS THE PAIN: <input type="checkbox"/> IMPROVING <input type="checkbox"/> CONSTANT <input type="checkbox"/> GETTING WORSE IS THE PAIN: <input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE ON A SCALE FROM 1 (MILD PAIN) TO 10 (SEVERE PAIN), THE PAIN IS A _____				
WHAT IS THE NATURE OF YOUR BODY PAIN? PLEASE DESCRIBE. <input type="checkbox"/> DULL ACHE <input type="checkbox"/> PRICKLY/NEEDLE-LIKE <input type="checkbox"/> STABBING <input type="checkbox"/> FIXED <input type="checkbox"/> MOVING				
WHAT MAKES IT FEEL BETTER? <input type="checkbox"/> HEAT <input type="checkbox"/> COLD <input type="checkbox"/> MOVEMENT <input type="checkbox"/> REST <input type="checkbox"/> OTHER WHAT MAKES IT FEEL WORSE? <input type="checkbox"/> HEAT <input type="checkbox"/> COLD <input type="checkbox"/> MOVEMENT <input type="checkbox"/> REST <input type="checkbox"/> OTHER				

PLEASE MARK THE PAIN AREAS ON THE PICTURE

