SAN FRANCISCO
INTEGRATIVE MEDICINE

Welcome and thank you for choosing San Francisco Integrative Medicine.
Our goal is to help you achieve your optimum health and wellness. This is a confidential questionnaire to help me determine the best treatment plan for you. If you have any questions please ask. Thank you.

PERSONAL INFORMATION

Name_______________________________________ Date__________________

Home Address_______________________________________

City_______________________ State_______________ Zip________________

Primary Phone_______________________ Email_______________________

Occupation_______________________ Work Phone_______________________

Person responsible for your account_______________________________________

Emergency Contact: Name_______________________ Phone_______________________

Sex: ☐ Male ☐ Female ☐ Trans (__MTF __FTM) ☐ Gender Queer Birthdate_______________ Age__________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered Number of Children ______________

Have you received acupuncture therapy before? ☐ Yes ☐ No Have you received facial acupuncture before? ☐ Yes ☐ No

When?_______________________ With whom?_______________________

Who should we thank for referring you? _______________________________________

SUPPLEMENTS AND MEDICATIONS

List any medications and supplements you are currently taking. Continue on back if necessary.

Medicine	Dose	Reason	How Long	Prescribed By	Date of Last Checkup

MEDICAL AND SOCIAL HISTORY

Please indicate any significant illnesses you or a blood relative (grandparent, parent, sibling) have had:

Illness	You	Relative	Approx. Date	Illness	You	Relative	Approx. Date
Cancer	☐	☐	_________	Diabetes	☐	☐	_________
Hepatitis	☐	☐	_________	Heart Disease	☐	☐	_________
High Blood Press	☐	☐	_________	Seizure	☐	☐	_________
Rheumatic Fever	☐	☐	_________	Emotional Disorders	☐	☐	_________
Infectious Disease	☐	☐	_________	Tuberculosis	☐	☐	_________

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows in the space to the left.
No mark ( ) = never experience, Check Mark (√) = sometimes experience, Plus Sign (+) = frequently experience

☐ Lack of Appetite	☐ Abdominal pain	☐ Eye issues	☐ Fatigue
☐ Excessive appetite	☐ Chest pains	☐ Jaundice (yellowish skin/eyes)	☐ Edema
☐ Loose stool or diarrhea	☐ Sciatic Pain	☐ Difficulty digesting oily foods	☐ Blood in stool
☐ Digestive problems	☐ Headaches	☐ Gall stones	☐ Black tarry stool
☐ Vomiting	☐ Pain or coldness in genital area	☐ Light Colored Stools	☐ Easily bruised

☐ Belching	☐ Cough	☐ Soft or brittle nails	☐ Difficult to stop bleeding
☐ Heartburn/reflux	☐ Shortness of Breath	☐ Easily angered or agitated	☐ Asthma
☐ Feeling of food retention in stomach	☐ Decreased sense of smell	☐ Difficulty in making plans or decisions	☐ Tendency to catch colds easily
☐ Tendency to become obsessive in work/relationship	☐ Nasal problems	☐ Spasms or twitching muscles	☐ Intolerance to weather changes
☐ Insomnia, difficulty sleeping	☐ Skin problems	☐ Low back pain	☐ Allergies
☐ Heart palpitations	☐ Feeling of claustrophobia	☐ Knee problems	☐ Hay fever
☐ Cold hands/feet	☐ Bronchitis	☐ Hearing impairment	☐ Dizziness
☐ Nightmares	☐ Colitis or diverticulitis	☐ Ear ringing	☐ Tendency to faint easily
☐ Mentally restless	☐ Constipation	☐ Kidney stones	☐ High cholesterol levels
☐ Laughing for no apparent reason	☐ Hemorrhoids	☐ Hair loss	☐ Sudden weight loss
☐ Angina pains	☐ Recent antibiotic use	☐ Decreased sex drive	☐ Other________________
		☐ Urinary problems	

SKIN CARE HISTORY

Please check any of the following which are of most concern to you:

- ☐ Bags / swelling under eyes
- ☐ Sagging face
- ☐ Wrinkles
  - ☐ Nasolabial
  - ☐ Eyes
  - ☐ Lips
  - ☐ Other:_______________________
- ☐ Vertical creases / furrows
- ☐ Premature graying of hair
- ☐ Droopy eyelids
- ☐ Double Chin
- ☐ Oil Skin
- ☐ Dry Skin
- ☐ Lusterless skin
- ☐ Acne
- ☐ Acne Scarring
- ☐ Rosacea
- ☐ Sun Damage
- ☐ Large Pores
- ☐ Broken Capillaries
- ☐ Protruding temporal veins

☐ Other Skin conditions / Issues:____

What improvements would you like to see?:

____

____

____

Describe any skin sensitivities or allergies:

____

____

Do you wear makeup daily? ☐ Yes ☐ No   Do you wear sunscreen daily? ☐ Yes ☐ No

Please describe your current skin care regimen and products that you use (toner, astringent, mask, moisturizer):

____

____

Do you get facial waxing / electrolysis / or us depilatories? ☐ Yes, wait approximately 5 days between treatments ☐ No

Please check all procedures you have had or are currently undergoing:

☐ Botox	Date(s):____________________	☐ Laser procedures	Date(s):__________________
☐ Collagen Injections	Date(s):____________________	☐ Threading	Date(s):__________________
☐ Restalyne	Date(s):____________________	☐ Rhytidectomy	Date(s):__________________
☐ Silicon Injection	Date(s):____________________	☐ Blepharoplasty	Date(s):__________________
☐ Mesotherapy	Date(s):____________________	☐ Brow or Coronal lift	Date(s):__________________
☐ Microdermabrasion	Date(s):____________________	☐ Other:________________	Date(s):__________________
☐ Chemical Peels	Date(s):____________________		