Lucas D. Brown, L.Ac.
Lucas@lucasbrown.com ● (312) 221-5258
1211 Baylor Rd. Suite 100 Austin, Texas 78703

Patient Information

Today's date:			Social Security Number:
○ Mr. ○ Miss ○ Mrs. ○ Ms. ○ Dr.			First name:
Birth date: (mm/dd/yy)			Last name:
Age:	Email:		
Marital status: ○ Single ○ Divorced ○ Married ○ Separated ○ Partner ○ Widowed			
Street address:			Apt:
City:	State:	Zip:	Country:
Phone number Work:		Mobile:	
How would you prefer for me to contact you?			
Emergency Contact: Relationship:			
Insurance Provider:	Type of Plan:		Member Number:
How did you learn about us? ○ Physician referral ○ Friend ○ Internet ○ Other (Please include the name if you were referred by a doctor or friend.) Name:			
Reason for visit: How, when, where did this condition begin? What Types of treatment have you tried? What improves the condition? What worsens the condition? How does this impact your day to day life?			

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General Health information

Height: ft. in.	Weight: lbs.	Primary physician: Phone:
Have you had acupuncture before:	If so, for how long:	
Chinese Herbal Medicine:	If so, do you know what:	
Do you have any allergies?		
Do you have, or have you ever had the following: ○ Cancer ○ Diabetes ○ Heart Disease ○ Hepatitis ○ HIV ○ AIDS ○ Stroke ○ Asthma ○ High blood pressure ○ Thyroid problems ○ Ulcers ○ Arthritis ○ Osteoporosis ○Seizures ○ Herpes ○ Chronic fatigue ○ Kidney Stones ○ Other:		
Blood Pressure:	Cholesterol Level:	
<u>How often do you use the following?</u> Cigarettes / Cigars: Alcohol: Drugs: Coffee: Artificial Sweeteners: Fast food:	<u>How often do you:</u> Run / Walk: Swim: Yoga: Bike: Weight Training: Gym / Fitness Class: Other:	
Please list any prescription or over-the counter medication you are currently taking:		
Please list any herbal medicine and other supplements you are currently taking:		
Have you ever been exposed or have suspicions of exposure to heavy metal toxicity? (Dental work, excessive fish consumption, lead paint, etc…) ○ Yes ○ No		

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If yes, please list:		
Have you had exposure to other known environmental toxins (mold, chemicals, etc.)? ○ Yes ○ No If yes, please list:		
How good do you feel your nutrition is?		
Describe your daily diet: (Please list the time you normally eat and where you normally are) Breakfast: Lunch: Dinner: Snacks:		
What foods do you crave?	What do you think is your worst eating habit?	What is your favorite treat?
How many hours on average to you sleep per night?		
Do you have problems falling asleep?		
Do you have problems staying asleep?		
Do you feel rested in the morning?		
How many bowel movements do you have a day?	Approximately, how many times do you urinate per day?	
Do you tend to run warm or cold?	Do you sweat easily?	
How would you describe your daily energy level?		

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Female Patients

Date last menses (period) began:	At what age did you have your first menstruation?	
Is your menstrual cycle: ○ Regular ○ Irregular	How long is your typical cycle?	How many days do you bleed in total?
Do you ovulate on your own? ○ Yes ○ No ○ Not Sure	Do you experience pain around ovulation?	
Do your breasts get tender around ovulation?	Do you chart your cycle? If so How?	
Check what describes your flow and the consistency and color of the blood: ○ Light ○ Watery ○ Dark red ○ Brown ○ Red ○ Purple ○ Pink ○ Moderate flow ○ Heavy flow ○ Thick ○ Clots		
Do you experience any of these PMS symptoms? ○ Breast tenderness ○ Cramps ○ Nausea ○ Fatigue ○ Acne ○ Moodiness ○ Headaches ○ Bloating ○ Change in bowel ○ Sleep disturbances ○ Night sweats ○ Other:	Do you experience menstrual pain? ○ No ○ Before ○ During ○ After ○ Intermittent Is the pain: ○ Stabbing ○ Cramping ○ Dull Ache ○ Heavy ○ On/Off What relieves the pain?:	
At which point in the cycle does your blood contain clots? ○ Never ○ Start ○ Midpoint ○ End	How many times have you been pregnant? How many children do you have? Have you had any miscarriages or stillborn births?	
Which forms of chemical contraception have you used, for how long and when did you stop? (time used/approx. date ended) Oral _____/_____ Depo-Provera _____/_____ IUD _____/_____ Other:		
Date of your last pap smear:	Have you ever been diagnosed with: Pelvic Inflammatory Disease: Uterine fibroids:	
Have you ever had an abnormal pap smear?	Do you experience vaginal discharge? If yes, please describe color, consistency and odor:	
Have you ever tested positive for a STD? (Yes/No) If yes, please list STDs:		

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Male Patients

Have you been diagnosed with prostate problems?	Do feel that you have a healthy sex drive?
Do you experience premature ejaculation?	Do you have any impotence problems?
Have you ever been tested for infertility?	
Have you ever tested positive for a STD? (Yes/No) If yes, please list STDs:	

Other

Is there anything that has not been asked that you would like to inform me of?

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Please indicate which of the following symptoms you have had recently and their severity on a scale of 1-5, where 5 is the worst you can bear.

Blurred vision	Abdominal pain	Absentminded / loss of memory
Brittle nails	Constipation	Angered easily
Depression	Loose Stools	Annoyed by little things
Stress	Aversion to cold	Changes in sexual energy
Dizziness	Bad breath	Emotional eating
Feeling of lump in throat	Bloating	Considered suicide
Genital itching	Gas	Difficulty making decisions
Headaches	Bruise easily	Difficulty relaxing
Migraines	Cold nose	Dislike criticism
Irritability	Muscle twitching	Experienced sexual abuse
Frustration	Difficulty getting up in the morning	Family problems
Crave sweets	Foggy mind	Feeling of depression
PMS	Neck / shoulder tension	Frequent crying
Red / Dry / Itchy Eyes	Fatigue after eating	Frightening dreams or thoughts
Heartburn	Heaviness in the head / body	Lack of concentration
Sensation or pain under rib cage	Hemorrhoids	Increased appetite
Sighing	Increased thirst	Nervousness or anxiety
Ankle swelling	Visual problems / floaters	Shy or sensitive
Intestinal pain / cramping	Bladder infection	Vivid dreams
Cold hands / feet	Sexual difficulties	Restless / easily agitated
Nausea / vomiting	Crave salty food	Palpitations
Overweight	Pensive / over-thinking	Sought psychiatric help
Skin rashes / hives	Insomnia	Prefer Warm / Cold drinks
Tinnitus	Bitter taste in mouth	Cough with phlegm
Worry a lot	Nasal discharge / drip	Sweat easily
Feel cold easily	Poor appetite	Frequent urination
Night sweats / hot flashing	Poor digestion	Allergies / Asthma
Hearing problem	Loss of head hair	Dry mouth / nose / throat
High sex drive	Low sex drive	Yeast infection
Aversion to heat	Weak immune system	Tongue / mouth ulcers / cankers