Acupuncture and Herbal Medicine Banya Lim L.Ac. www.banyalim.com

Name: ________________________________ DOB:______________________________

Date: _____/_____/____________ Gender: F M

Contact info

Phone No.:________________________________

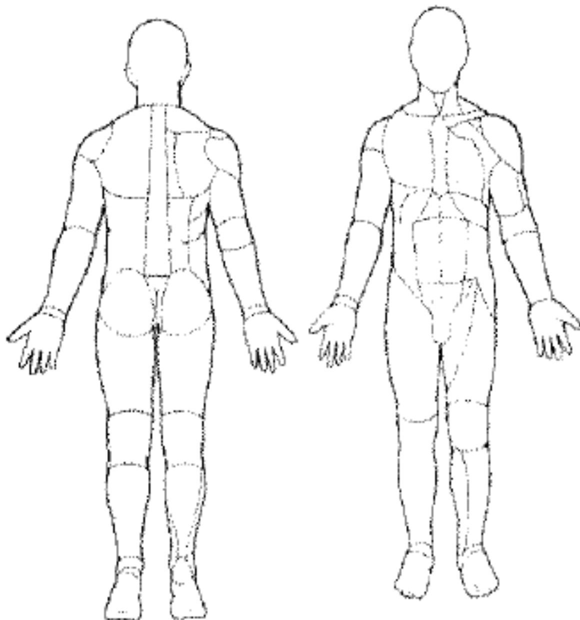
Address:____

Email:____

1.What are the concerns for which you are seeking care? (symptoms, diagnosis and date of onset)

2. What other treatments have you received for any of these conditions?

3. Please mark the areas that you are experiencing pain



4. Medical and Family History

Please list your current and past diagnoses(if any):
Please list past hospitalization and surgical procedures(include years possible)
List any known allergies to medications, foods or other substances as well as your reaction:
Have you traveled outside the United States in the past two years Yes No Where?

Family History

List any serious health conditions your family members have experienced. Including diabetes, heart disease, autoimmune disease, cancer, addictions, eating disorders, mental disorders, allergies, genetic disorders, or any other major concerns

Condition:	Family Member:	Age of onset/Age of death

5. Medications and Supplements

List all current medications, vitamins, herbs, and other supplements you take, including dosage

Medications:	Vitamins, Herbs and other Supplements:

6. Personal History

Cancer___________ Diabetes _____________ Seizures Heart Disease _______________
High/Low Blood Pressure _______________ Stroke ______________ Auto Immune ___________________
Anemia _________________ Kidney Disease ____________________ Hepatitis ________________
Thyroid Imbalance ____________ Asthma ________________ Eating Disorder ________________
Arthritis ____________ Ulcer _____________ Alzhemers _____________ Alchohol/Drug Addiction ___________
Chronic Fatigue __________ Blood Clotting Disorder _______________ Prolapsed Organ _________________
Chronic Pain ____
Do you smoke? (Tobacco or Marijuana) For how long? ______________ How much a dau?________________
Other serious Health Condition ____