Questionnaires

For those who have never visited us

PLEASE PRINT

Patient Name Last : First:

Date of birth : Age Sex

Address :

Phone : Email:

★ How did you find us?

Recommended by family or friends ( ) Phone book ( )

Internet ( ) Referred by a doctor ( )

◆ Briefly describe the reason for your visit.

◆ List of questions you may have

◆ Are you allergic to any medications or food?

◆ List any medical problems that other doctors have diagnosed.

◆ List of prescription medications, over the counter meds, Chinese medicines and supplements

◆ Have you had Blood tests, MRI, CT scan, EMG or EEG？

◆ Please tell us about any surgeries you have undergone.

◆ Have you ever been seriously ill or badly injured?

◆ Are there any family members who have similar symptoms?

◆ Cigarettes　pks/day

◆ Alcohol: never( ) occasional( ) moderate( ) heavy( )

How many drinks might you have in a typical week?

◆ Are you right-handed or left handed?

◆ Current weight:　kg

weight loss/gain in the last year

◆ Do you sleep well?