American Chinese Medicine Association

ACMA New Patient Form
(ACMA Condition Form)

This form is required for all new patients. To be accurate and prevent errors, please type your answers into the form, print it, and bring it at your first appointment.

Patient	Name			
	Gender			
	Birth Date			
	Address			
	City			
	State		Zip Code	
	Country			
	Phone			
	Email			
Contact Person	Name			
	Relationship with Patient			
	Phone			
	Email			
Attending Physician	Name			
	Phone			
	Email			
How did you hear ACMA?				
Do you have health insurance?				
If yes, what's your insurance company and plan?				
Questions		**Answers**		
What are the patient's chief complaints?				

Current Diseases, Signs, and Symptoms Please list all diseases, signs and symptoms the patient has now.	
What are the date and location when the illness first occurred and diagnosed?	
When and what lab tests has the patient done?	
What are the lab test results and conclusions? **Lab Reports** To help your treatments, please make a copy of all lab reports, and bring them during the visit or mail them to ACMA.	
Is there family history of the illness?	
What treatments the patient has received?	
What medications (pharmaceutical drugs) the patient is taking? Please indicate the dosages and function (for what disease) of each drug.	
When did the patient start taking above medications?	

What are above treatment results?	
History of Other Diseases Please list all other diseases, signs, and symptoms the patient had before. Please indicate the time when the patient got them.	
Is the patient allergic to any medications (drugs) such as penicillin? If yes, please describe what allergic reactions will happen.	
Is the patient allergic to any foods such as grains, beans, peanut, etc.? If yes, please describe what allergic reactions will happen.	
Is the patient sensitive to medications (drugs) or any treatments?	
Does the patient easily get sweating?	
If sweat, when does the sweating occur (during day time or in the night during sleep)?	
If sweat, which parts of the body get sweating?	
What's the patient's sleep condition in the night?	
Can the patient fall sleep easily?	
Does the patient feel sleepy during the day time?	
Does the patient feel dizzy?	
Does the patient feel headache?	
Does the patient frequently feel head hot?	
Does the patient frequently feel face hot?	

Does the patient often feel mouth dry?	
Does the patient often feel thirsty?	
What kind of water the patient wants to drink (cold water or warm water)?	
Does the patient have mouth flavor? If yes, what flavor (sour, bitter, sweet, acrid, salty, or none, etc).	
What's the temperature of the patient's hands (cold, warm, or hot)?	
What's the temperature of the patient's feet (cold, warm, or hot)?	
Does the patient feel arm pain? If yes, where (upper or lower part)?	
Does the patient feel arm numb? If yes, where (upper or lower part)?	
Does the patient feel leg pain? If yes, where (upper or lower part)?	
Does the patient feel leg numb? If yes, where (upper or lower part)?	
Does the patient feel the leg heavy?	
Does the patient have edema (swelling)? If yes, please indicate where the edema locates.	
Does the patient feel chest tightness?	
Does the patient feel chest pain?	
Does the patient feel neck tight and rigid?	
Does the patient feel upper back pain?	
Does the patient feel waist, lower back pain?	
Does the patient feel back cold, warm, hot?	
Does the patient feel short of breath and have difficulty in breathing?	
Does the patient cough?	
If yes, when cough the most?	
Does the patient have stuffy nose?	
Does the patient have running nose?	

What's the color of the patient's nasal discharge (clear, white, yellow, green)?	
Does the patient have sinus pressure?	
Does the patient feel body hot?	
Does the patient feel body cold?	
What clothes does the patient often wear (more clothes than other people, less clothes than other people, or same clothes as other people)?	
Does the patient like warm weather, cold weather, or have no preference?	
Does the patient fear cold or fear warm?	
Does the patient feel body chill?	
Does the patient's disease become worse in a specific season (summer, winter, or no difference)?	
When does the patient feel better, summer or winter?	
Does the patient easily get fatigue and tired?	
What's the patient's energy level (on a scale: Lowest 0 – Highest 10)?	
Does the patient feel depressed?	
Does the patient have anxiety feeling?	
Does the patient have a fast temper and easily get angry?	
What about the patient's appetite (good, average, or bad)?	
Does the patient feel hungry before meal?	
Does the patient feel stomach bloating?	
Does the patient like to eat cold foods, warm foods, or no preference?	
Does the patient feel nauseous? If yes, when does it happen usually (e.g. before or after meal, etc.)?	
Does the patient vomit? If yes, when does it happen usually?	
Does the patient have jaundice? If yes, where is the jaundice located?	

Does the patient have acid reflux?	
Does the patient have regurgitation?	
Does the patient have hiccup?	
Does the patient have borborygmus (intestinal sound from abdomen)?	
Does the patient have excessive flatus (gas)?	
Does the patient feel abdominal bloating?	
How many times does the patient have bowel movement a day?	
If does not have bowel movement everyday, how many bowel movements in a week?	
What's the state of the feces (stool) (well-formed, loose, fluid, or dry)?	
What's the color of the feces (stool)?	
During the daytime, how often does the patient urinate (how many hours between two urinations)?	
How many times does the patient urinate during the night?	
How about the urine amount (normal, low, high)?	
Does the patient have problem with urination?	
What's the urine color (yellow, slightly yellow, or clear)?	
Does the patient have any bleeding?	
Does the patient have skin rashes?	
Where are the skin rashes located?	
Does the patient feel skin itchy?	
Where is the itchy skin located?	
Does the patient have any spots on the skin?	
What's the color of the skin spots (red, dark, purple)?	
Where are the skin spots located?	

How large are the skin spots?	
What's the temperature of the patient's abdomen (warm or cold)?	
Does the patient have abdominal pain?	
If has abdominal pain, when does his abdominal pain occur each day (before eating or after eating)?	
If has abdominal pain, are there any triggering events (e.g. the food intake, or any other events) that might lead to the abdominal pain?	
In one day (or in one week if the patient does not eat the same foods each day), what percentage of foods does the patient usually eat? Please indicate whether the foods are at room temperature, from refrigerator, or heated by stove, microwave, etc.	**Carbohydrates** (bread, pasta, pizza, noodle, etc.): **Animal Foods** (egg, chicken, fish, beef, pork, milk, cheese, butter, etc.): **Fruits**: **Vegetables**:
What drinks the patient usually has? Please indicate the temperature of the drinks (e.g. at room temperature, from refrigerator, or heated by stove, microwave, etc.)	
What is the patient's height?	
What is the patient's current weight the first thing in the morning when get up?	
What's the patient's blood pressure (BP)?	
What's the patient's pulse?	
What is the thermometer reading of the patient's body temperature?	
For diabetes patient, what is the patient's blood sugar level before taking diabetes meds and/or insulin?	
For diabetes patient, what is the patient's blood sugar level after taking diabetes meds and/or insulin?	
Special measurement (e.g. girth, etc.)	

For cancer patients, 1. Currently how many cancer tumors does the patient have? 2. Where are the tumors located? 3. What are the sizes of the cancer tumors?	
How is the patient's living environment and condition?	
What job does the patient do? Does the job require office sitting, standing, or traveling?	
For Female Patients	
Does the patient have menstruation?	
If yes, is the menstruation period normal (on time), delayed, or ahead of time?	
Is the menstruation color red, dark, or black?	
Are there any clots or blood chunks in the menstruation?	
Is there any abnormal vaginal discharge?	
What's the color of leukorrhea (clear, white, or yellow)?	
Additional Information	
Besides above questions, if there are any other signs, symptoms, and conditions not covered above, please put them in details in the right column.	

Allergic Reactions

Most patients are fine after receiving ACMA support. Only very small percentage of patients are allergic to ACMA support. If you get allergic reactions to ACMA support (including any new signs and symptoms appearing after taking ACMA

support), please call ACMA asap. The allergic reactions are not dangerous, and ACMA has many methods that can remove allergic reactions very quickly as long as you call ACMA asap.

Policy

ACMA will not share patients' information with any third party.

Because ACMA support is based on each patient's individual specific conditions, each support is prepared for one patient only, and the support cannot be shared and used by other patients. Due to this reason, after patients have ordered ACMA support, the support cannot be returned and refunded because no other patients can share and use the returned support.

Signature: _____

Print Your Name: _____

Date: _____