Xu Wellness Center
235 Germantown Bend Cove
Cordova, TN 38018
Phone: (901) 737-8282
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www.XuWellnessCenter.com

New Patient Information

Name			Date	
Street Address			Sex	
City State Zip			Date of Birth	
Mobile Phone	Marital Status		Height	Weight
Mobile Provider	Work Phone			
Home Phone	Maiden/ Former Name			
Email	Primary Physician			
Social Security Number	Driver's License Number and State			
Occupation	Employer			
Referred by	Other Family Members Seen Here			

Emergency Contact Information:

____
Name Relationship

____
Mobile Phone Home Phone Work Phone

Medical History

What is your primary health complaint/ concern?

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Have you seen a MD for this complaint/ concern? Was there a diagnosis?

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Please list all surgeries and hospital stays; please include the date and procedure:

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Please list all significant traumas (auto accidents, falls, broken bones) and dates:

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Please list all significant childhood illnesses and/ or injuries:

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Please list ALL allergies, include food sensitivities:

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Check all symptoms that you experience on a regular basis:

Skin and Hair:

☐ Eczema	☐ Hair Loss	☐ Rashes
☐ Hives	☐ Pimples/ Acne	☐ Ulcerations
☐ Purpura	☐ Changes in Hair/ Skin	☐ Dandruff
☐ Itching	☐ Psoriasis	☐ Brittle Nails
☐ Warts	☐ Hives	☐ Shingles
☐ Dry Hair/ Skin	☐ Fungal Infections	☐ Pale Pallor

☐ Boils	☐ Painful Scars/ Wounds	☐ Other:

Head/ E.E.N.T.

☐ Loss of Smell	☐ TMJ Pain	☐ Clicking in Jaw
☐ Poor Vision	☐ Dizziness	☐ Blurry/ Double Vision
☐ Concussions	☐ Nosebleeds	☐ Sore/ Dry Throat
☐ Migraines	☐ Glasses	☐ Sinus Problems
☐ Dry Mouth	☐ Night Blindness	☐ Nasal Congestion
☐ Teeth Grinding	☐ Paralysis	☐ Glaucoma (Eye Pressure)
☐ Sinus Infections	☐ Copious Saliva	☐ Eye Strain
☐ Ringing in Ears	☐ Teeth Problems	☐ Facial Pain
☐ Color Blindness	☐ Poor Hearing	☐ Sore/ Bleeding Gums
☐ Eye Pain	☐ Earaches	☐ Mouth/ Tongue Sores
☐ Cataract	☐ Loss of Balance	☐ Bad Taste in Mouth
☐ Spots in Eyes	☐ Mucus	☐ Dry Throat
☐ Watery Eyes	☐ Facial Tics	☐ Headaches
☐ Hoarse Throat	☐ Itchy Eyes	☐ Teeth Loss
☐ Excessive Sneezing	☐ Loss of Taste	☐ Teeth Pain
☐ Loss of Strength/ Feeling	☐ Bad Breath	☐ Dry Eyes
☐ Difficulty Swallowing	☐ Excessive Nasal Drip	☐ Sore Tongue
☐ Frequent Colds	☐ Other Neck/ Head Problems:	

Cardiovascular

☐ Chest Pains	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Palpitations	☐ Blood Clots	☐ Leg Cramps
☐ Irregular Heart Beat	☐ Fainting Spells	☐ Swelling in Extremities
☐ Heart Attack	☐ Heart Disease	☐ Phlebitis
☐ Pressure/ Tightening in Chest	☐ Murmur	☐ Rapid Heart Beat
☐ Spider Veins	☐ Varicose Veins	☐ Mitral Valve Prolapse
☐ Pacemaker	☐ Skipped Heartbeats	☐ Blood Disorder
☐ High Cholesterol	☐ Raynaud’s Disease	☐ Other:

Gastrointestinal

☐ Indigestion	☐ Nausea	☐ Pain/ Cramps
☐ Hemorrhoids	☐ Vomiting	☐ Bad Breath
☐ Rectal Pain	☐ Irregular BMs	☐ Gas
☐ Constipation	☐ Bloody Stools	☐ Recent Weight Loss/ Gain
☐ Belching	☐ Diarrhea	☐ Black Stools
☐ Laxative Use	☐ Enema Use	☐ IBS
☐ Rectal Itch	☐ Bloating	☐ Acid Reflux
☐ Slow Digestion	☐ Hiatal Hernia	☐ Gallbladder Problems
☐ Liver Problems	☐ Fecal Incontinence	☐ Stomachache
☐ Bitter Taste in Mouth	☐ Colitis	☐ Sweet Taste in Mouth
☐ Intestinal Parasites	☐ Ulcer	☐ Stomach Gurgling
Number of BMs Daily:	☐ Other:	

Respiratory

☐ Asthma	☐ Bronchitis	☐ Difficulty Breathing While Lying Down
☐ Shortness of Breath	☐ Cough	☐ Shortness of Breath on Exertion
☐ Seasonal Allergies	☐ Excessive Phlegm	☐ Coughing Blood
☐ Emphysema	☐ Tight Chest	☐ Chronic Colds
☐ Tuberculosis	☐ Pleurisy	☐ Rheumatic Fever
☐ Pneumonia	☐ Dry Cough	☐ Wheezing/ Gasping
☐ Whooping Cough	☐ Sleep with Head Propped up	☐ Other:

Endocrine

☐ Thyroid Cancer	☐ Hypoglycemia	☐ Adrenal Disorders
☐ Night Sweats	☐ Hypothyroidism	☐ Hyperthyroidism
☐ Metabolic Disorder	☐ Diabetes, type:	☐ Goiter
☐ Thyroiditis	☐ Thyroid Hormone Resistance	☐ Sex Hormone Disorders
☐ Glandular Tumor	☐ Other:	

Genitourinary

☐ Bladder Infections	☐ Urgency to Urinate	☐ Unable to Hold Urine
☐ Kidney Stones	☐ Dribble Urine while Sneezing/ Coughing	☐ Blood in Urine
☐ Painful Sex	☐ Wake up to Urinate	☐ Difficulty Starting Stream
☐ Burning/ Pain while Urinating	☐ STDs:	☐ Impotency
☐ Frequent Urination	☐ Kidney Infections	☐ Bladder Infections
☐ Infertility	☐ Cloudy Urine	☐ Wetting the Bed
☐ Weak Urine Stream	☐ Kidney/ Bladder Pain	☐ Bladder Reflux
☐ Frequent Urinary Tract Infections	☐ Other:	

Gynecological (Women Only)

☐ Vaginal Infections	☐ Breast Lumps	☐ Vaginal Discharge
☐ Clots	☐ Breast Discharge	☐ Vaginal Sores
☐ Vaginal Bleeding between Periods	☐ Vaginal Bleeding (Not with Menses)	☐ Painful Menses
☐ Fibroids	☐ Endometriosis	☐ Ovarian Cysts
☐ Vaginal Itching	☐ Yeast Infections	☐ Abortions:
☐ Irregular Menses	☐ Retain Water	☐ Breast Tenderness
☐ Increased Sex Drive	☐ Decreased Sex Drive	☐ PMS
☐ PID	☐ Changes in Body/ Psyche Prior to Menses	☐ Menopausal
☐ Gynecological Surgeries	☐ Hysterectomy	☐ Hot Flashes
☐ Hormone Replacement Therapy	☐ Recent Change in Menstrual Flow	☐ Sexually Active
☐ Gynecological Cancer	☐ Tubal Ligation	☐ Tubal Pregnancy
☐ Birth Control, type:		
☐ Currently Pregnant, Month:		☐ Other:
☐ Premature Births:	☐ Miscarriages:	

Date of Last Period:_______________ Duration of Periods:_______________

Date of Last Pap:______________Date of Last Mammogram:_____________

Number of Pregnancies:______________ Number of Births:_____________

Is your flow regular, heavy, or light, please explain if unusual:

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Men Only

☐ Prostate Cancer	☐ Hernia	☐ Nocturnal Emissions
☐ Enlarged Prostate	☐ Loss of Erection	☐ Prostatitis
☐ Genital/ Jock Itch	☐ Premature Ejaculation	☐ Pain in Testes/Penis
☐ Increased Sex Drive	☐ Decreased Sex Drive	☐ Low Sperm Count
☐ Groin Pain	☐ Testitis	☐ Hair Loss
☐ Testicular Cancer	☐ Penile Cancer	☐ Other:

Musculoskeletal and Neurological

☐ Low Back Pain	☐ Neck Pain	☐ Muscle Pain
☐ Joint Pain	☐ Muscle Spasms/ Cramps	☐ Muscle Weakness
☐ Paralysis	☐ Poor Coordination	☐ Loss of Feeling
☐ Upper or Middle Back Pain	☐ Numbness/ Tingling:	☐ Pain Down Legs
☐ Degenerative Disease:	☐ Diseases/Disorders of the spine	☐ Brain Tumor
☐ Swollen Joints	☐ Bone Problems/ Pain	☐ Osteoporosis
☐ Vertigo	☐ Stroke	☐ Genetic Neurologic Disorder:
☐ Arthritis	☐ Disk Issues	☐ Fractures
☐ Joint Replacement	☐ Leg Cramps	☐ Chronic Pain:
☐ Acute Pain:	☐ Tremors	☐ Whiplash
☐ Torticollis	☐ Gout	☐ Stiff Neck
☐ Seizures	☐ Concussion	☐ Poor Memory
☐ Sprains/ Strains	☐ Noisy Joints	☐ Other:

If you are experiencing pain, please describe frequency, duration, and location:

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Psychological/ Emotional/ Sleep

☐ Depression	☐ Bad Temper	☐ Mood Swings
☐ Wakens Easily	☐ Anxiety	☐ Easily Stressed
☐ Considered Suicide	☐ Attempted Suicide	☐ Unable to Fall Asleep
☐ Unable to Stay Asleep	☐ Feelings of Unhappiness	☐ Poor/Restless Sleep
☐ Insomnia	☐ Heavy Sleep	☐ Excessive Worry
☐ Easily Overwhelmed	☐ Excessive Fears	☐ Difficulty making Decisions
☐ Nightmares	☐ Obsessive Tendencies	☐ Inability to Focus
☐ Unmotivated	☐ Optimistic	☐ Pessimistic
☐ Hyperactivity	☐ Other:	

If you have been diagnosed with a psychological/ emotional problem, please explain:

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____

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Other

☐ HIV/ AIDS	☐ Fibromyalgia	☐ Chronic Fatigue Syndrome
☐ Hepatitis	☐ Drug/ Alcohol Addiction	☐ Cancer:
☐ Strong Cravings	☐ Cold Back	☐ Strong Thirst
☐ Prefer Cold Drinks	☐ Prefer Hot Drinks	☐ Cold Abdomen
☐ Fevers	☐ Peculiar Tastes/ Smells	☐ Sweats Easily
☐ Excessive Sweating	☐ Sudden Drop in Energy	☐ Overall Poor Condition
☐ Lumps/ Bumps	☐ Chills	☐ Cold Hands
☐ Lack of Perspiration	☐ Bleed/ Bruise Easily	☐ Anemia
☐ Cold Feet	☐ Fatigue	☐ Bleed Excessively When Cut

☐ Heavy Appetite	☐ Poor Appetite	☐ Change in Appetite

Describe your overall energy level:____

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____

Family Medical History

Has anyone in your family suffered from the following?

☐ Diabetes	☐ Asthma	☐ Cancer:
☐ Seizures	☐ High Blood Pressure	☐ Heart Disease
☐ Stroke	☐ Allergies	☐ Obesity
☐ Alcoholism	☐ Thyroid Problems	☐ Arthritis
☐ Psychological/ Emotional Problems	☐ High Cholesterol	

Lifestyle

Average Daily Diet

Breakfast____

____

Lunch____

____

Dinner____

____

Habits/ Please Include Amount

☐ Cigarettes/ Per Day?	☐ Coffee/ Per Day?	☐ Tea/ Per Day?
☐ Alcohol/ Drinks Per Week?	☐ Sugar/ How Often?	☐ Table Salt/ How Often?
☐ Fatty Foods/ How Often?	☐ Soda/ How Often?	☐ Drugs/ How Often?
☐ Other/ Frequency?		

Do you exercise regularly? If so, what type and how often?_________________________

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How much water do you drink daily?____

Medication List

Please list all prescription and non-prescription medication, along with any vitamins, herbs, and supplements that you are currently taking.

Please place an X on your problematic areas.

Medication/ Supplement	Dose	How Long?	How Often?

Informed Consent

The above information is true to the best of my knowledge. I understand that I am financially responsible to Xu Wellness Center for payment at time service is rendered. I authorize Xu Wellness Center to contact me at the above contact information. I understand that I am responsible for all returned checks and must pay the price on the check plus a $30 bounced check fee. I understand that my personal information is private and will not be shared with anyone unless a written request is made to Xu Wellness Center written and signed by me.

Chinese herbal medicine is considered safe, and it is my responsibility to inform Xu Wellness Center if any changes in my health occur. I am responsible for informing Xu Wellness Center of any and all health conditions, diseases or disorders from which I suffer. Serious health conditions or injuries will be referred to the appropriate physician, clinic or hospital.

I understand that I still need to continue any medical treatment that I am receiving through my physician. I understand that I have the right to refuse treatment at any time, and I have the right to end my treatments at any time. I also understand that I have a right to ask whatever questions I have before, during, or after my treatments. I understand that Xu Wellness Center is not to be held responsible for any unexpected complications that may occur, and I understand that results are not guaranteed.

I voluntarily consent to being treated by Traditional Chinese Medicine in any of the following ways:

- Acupuncture- small sterilized needles will be inserted into the skin at various points along my body
- Electrical Stimulation- a small electrical current is applied to the acupuncture needle
- Ear acupuncture or Stapling- small surgical staples are placed in various acupoints in the ear or ears, mostly in order to treat addictions
- Medicinal Herbal Tea/ Capsules/ Lotion- herbal medicine that is given in tea form will need to be prepared and consumed at home.
- Tuina massage therapy- deep tissue massage modality in which light bruising may occur
- Cupping- treatment in which hot glass cups are placed directly on the skin, red circular marks will remain for several days and bruising oftentimes occurs
- Moxibustion- acupoints are heated either directly or indirectly and the herb mugwort is burned during treatment. There is a slight risk of a burn or small scar to be left on the skin
- Spinal Traction Therapy- the spine is gently pulled with the aid of a machine
- Tai Chi & Qigong exercises could be taught and are gentle, safe slow moving exercises that combine movement and breathing
- Diet and exercise plans are customized and differ from person to person. Xu Wellness Center is not responsible for any injuries that may occur. (Please discontinue any exercise that causes pain) Xu Wellness Center is not responsible for any food reactions that may occur. (Please list all allergies in health history section above)

I understand the treatment or treatments that I am about to receive. I have read this consent form, and I completely understand what I am signing. I consent to be treated at Xu Wellness Center, and I agree to abide with all terms and conditions before mentioned.

Patient Signature X____

Please Print Name__________________________________ **Date**___________

If under 18/ Guardian
Signature____

For Doctor's Use Only

Progress Notes

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