



*Ferrari Center of Chinese Medicine*  
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Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Blood Type: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Referred By: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_



age \_\_\_\_\_

gender \_\_\_\_\_

complaint \_\_\_\_\_

\_\_\_\_\_

significant illnesses \_\_\_\_\_

\_\_\_\_\_

operations

\_\_\_\_\_ age \_\_\_\_\_

\_\_\_\_\_ age \_\_\_\_\_

\_\_\_\_\_ age \_\_\_\_\_

\_\_\_\_\_ age \_\_\_\_\_

have you been told that you have had any of the following conditions:

yes    no

- |       |       |  |
|-------|-------|--|
| _____ | _____ | asthma   |
| _____ | _____ | anemia   |
| _____ | _____ | arthritis  |
| _____ | _____ | cancer   |
| _____ | _____ | candidiasis  |
| _____ | _____ | colitis  |
| _____ | _____ | diabetes   |
| _____ | _____ | epilepsy   |
| _____ | _____ | gout   |
| _____ | _____ | hepatitis  |
| _____ | _____ | high blood pressure  |
| _____ | _____ | hiv  |
| _____ | _____ | legionaire's disease   |
| _____ | _____ | lyme's disease   |
| _____ | _____ | kidney disease   |
| _____ | _____ | osteoporosis   |
| _____ | _____ | peptic ulcer   |
| _____ | _____ | pneumonia  |
| _____ | _____ | psychiatric problems   |
| _____ | _____ | rheumatic fever  |
| _____ | _____ | sexually transmitted disease (if yes, please specify: _____) |
| _____ | _____ | thyroid disease  |
| _____ | _____ | tuberculosis   |
| _____ | _____ | whooping cough   |

list all medications you are now taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

allergies: \_\_\_\_\_  
\_\_\_\_\_

SOCIAL HISTORY



birthplace: \_\_\_\_\_

current occupation: \_\_\_\_\_

any symptoms related to your work: \_\_\_\_\_

stress or pressure related to work:

none \_\_\_ low \_\_\_ medium \_\_\_ high \_\_\_

hobbies: \_\_\_\_\_  
\_\_\_\_\_

single \_\_\_ separated \_\_\_ divorced \_\_\_ married \_\_\_

any relationship stress: \_\_\_\_\_

education: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

how much alcohol: \_\_\_\_\_

any history of alcohol related problems: \_\_\_\_\_  
\_\_\_\_\_

do you smoke: \_\_\_\_\_

how much: \_\_\_\_\_

did you smoke: \_\_\_\_\_

how much: \_\_\_\_\_



FAMILY HISTORY:

if living, give age and health; if deceased give age and cause of death:

mother: \_\_\_\_\_

grandmother: \_\_\_\_\_

grandfather: \_\_\_\_\_

father: \_\_\_\_\_

grandmother: \_\_\_\_\_

grandfather: \_\_\_\_\_

sisters or brothers:

1 \_\_\_\_\_ 4 \_\_\_\_\_

2 \_\_\_\_\_ 5 \_\_\_\_\_

3 \_\_\_\_\_ 6 \_\_\_\_\_

husband or wife: \_\_\_\_\_

children:

1 \_\_\_\_\_ 2 \_\_\_\_\_

3 \_\_\_\_\_ 4 \_\_\_\_\_

5 \_\_\_\_\_ 6 \_\_\_\_\_

is there a history of the following in your family; include grandparents, aunts, uncles, cousins:

yes	no		yes	no	
___	___	alcoholism	___	___	allergies
___	___	anemia	___	___	asthma
___	___	bleeding tendencies	___	___	cancer
___	___	diabetes	___	___	embolisms
___	___	glandular tumors	___	___	high blood pressure

YOUR SYMPTOMS:

yes	no	
___	___	chronic fatigue
___	___	general weakness
___	___	easily bleed or bruise
___	___	loss of appetite
___	___	vomiting
___	___	pain in stomach or abdomen
___	___	indigestion
___	___	flatulence
___	___	change in bowel habits

- diarrhea
- constipation
- black, gray, or bloody stools
- ulcers



YOUR SYMPTOMS:

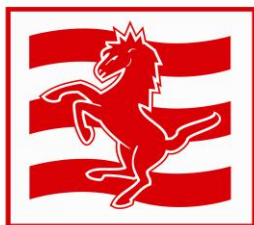
- | yes                      | no                       |                                    | yes                      | no                       |                     |
|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | hemorrhoids                        | <input type="checkbox"/> | <input type="checkbox"/> | hay fever           |
| <input type="checkbox"/> | <input type="checkbox"/> | liver problem or jaundice          | <input type="checkbox"/> | <input type="checkbox"/> | cough               |
| <input type="checkbox"/> | <input type="checkbox"/> | gallbladder problems or gallstones | <input type="checkbox"/> | <input type="checkbox"/> | cough up blood      |
| <input type="checkbox"/> | <input type="checkbox"/> | dry eyes                           | <input type="checkbox"/> | <input type="checkbox"/> | asthma              |
| <input type="checkbox"/> | <input type="checkbox"/> | blurry vision                      | <input type="checkbox"/> | <input type="checkbox"/> | frequent colds      |
| <input type="checkbox"/> | <input type="checkbox"/> | headaches                          | <input type="checkbox"/> | <input type="checkbox"/> | shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | eye pain                           |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | irritable or frustrated            |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | depressed                          |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | problems with sex                  |                          |                          |                     |
| <br>                     |                          |                                    |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | swelling of feet or ankles         |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | kidney or bladder infection        |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | trouble with balance               |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | low back pain                      |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | pain or burning urination          |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | urinate more than once a night     |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | unusual smell or color of urine    |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | kidney stones                      |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears                    |                          |                          |                     |
| <br>                     |                          |                                    |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | memory problems                    |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | chest pain                         |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | trouble talking                    |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | trouble sleeping                   |                          |                          |                     |
| <input type="checkbox"/> | <input type="checkbox"/> | anxiety                            |                          |                          |                     |

WOMEN

- | yes                      | no                       |                               |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | when was last cycle           |
| <input type="checkbox"/> | <input type="checkbox"/> | clots in menstrual blood      |
| <input type="checkbox"/> | <input type="checkbox"/> | loss of appetite before cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | feel cold before cycle        |
| <input type="checkbox"/> | <input type="checkbox"/> | irritable or frustrated       |
| <input type="checkbox"/> | <input type="checkbox"/> | depressed                     |
| <input type="checkbox"/> | <input type="checkbox"/> | dry skin                      |

MEN

- | yes                      | no                       |                                 |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | prostrate trouble               |
| <input type="checkbox"/> | <input type="checkbox"/> | small stream of urine           |
| <input type="checkbox"/> | <input type="checkbox"/> | trouble starting urine          |
| <input type="checkbox"/> | <input type="checkbox"/> | discharge from penis            |
| <input type="checkbox"/> | <input type="checkbox"/> | hernia                          |
| <input type="checkbox"/> | <input type="checkbox"/> | impotence                       |
| <input type="checkbox"/> | <input type="checkbox"/> | itching around penis or scrotum |
| <input type="checkbox"/> | <input type="checkbox"/> | problems with penis, scrotum    |



**Thank you, L. Francesca Ferrari, L.Ac.**