Dr. Yvonne Corcoran, D.O.M., LLC
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During your first visit, I hope to come to understand your health concerns, answer questions you may have and give you an examination/treatment using the Oriental medical approach. After your examination, we will review the results together and look at options available for treatment of your condition. If you elect to undertake treatment, we will begin as soon as possible. Treatment often begins at one's first visit.

It is important that you are on time for all appointments. A certain amount of time is allotted for each patient visit. If you are late, your remaining time may not be sufficient for your full treatment. The office visit fee will still apply. Should you need to reschedule or cancel your appointment, please contact the office a minimum of 24 hours in advance to avoid the $20.00 cancellation fee.

This practice is built on referrals. If you know someone who may benefit from acupuncture and/or Chinese herbal medicine, please take a business card or educational pamphlet for them. For each referral, you will receive 50% off your next visit.

Some of the questions below may seem unrelated to your condition. They do however play a major role in diagnosis and successful treatment, as this is a holistic medical realm.

PLEASE NOTE: ALL INFORMATION IS CONFIDENTIAL.

Name _____ Date ___/____/____
Address _____
City _____ State ____ Zip _____ Phone (home) _____(cell)_____ May I leave a message? Y/N
Age _____ Sex: M/F Height ___'___'' Weight _____
Date of Birth _____/_____/_____ Occupation _____
Physician's name ____ _____ Phone _____ May I contact? Y/N
Emergency Contact _____ Phone _____
How Did You Hear About This Office? (Including Referrals)_____
Who is responsible for payment? Health Insurance/HMO/PPO_____ Auto Insurance_____
Workman's comp____ Personal Injury_____ Self Pay_____

Main Health Concerns/ Primary Reason for this Visit:

How & When (please give exact date if injury/accident) Did This Condition Begin?

How Does This Condition Impair Your Daily Activities?

Please list the three main health complaints (include physical and emotional) that you wish to be free of.

1.

2.

3.

Personal Medical History- please circle and comment in space provided if you wish to give more information.

Diabetes	Bleeding Tendency/Bruising
Glaucoma	Tuberculosis
Heart Condition	Mumps
High Blood Pressure	Pneumonia
Arthritis- Osteo or Rheumatoid	Allergies/Type
High Fevers	Multiple Sclerosis
Vein Problems	Hepatitis/Type
Cancer	Kidney Disease
Asthma	Eating Disorder
Jaundice	Chronic Fatigue Syndrome
STD	Fibromyalgia
HIV	Lupus
Antibiotic Use (frequent)	Other Autoimmune Disorder
Mental Illness	Miscarriage
Irritable Bowel Syndrome	

Date/ Results of Exams

Physical _____ Cholesterol _____ HIV _____
Prostate _____ Pap smear_____ Mammogram _____
Hepatitis _____Blood tests (which) _____
Other/Comments _____

List all prescription medications /herbal supplements you are currently taking- include what they are for.

_____
_____
_____
_____
_____

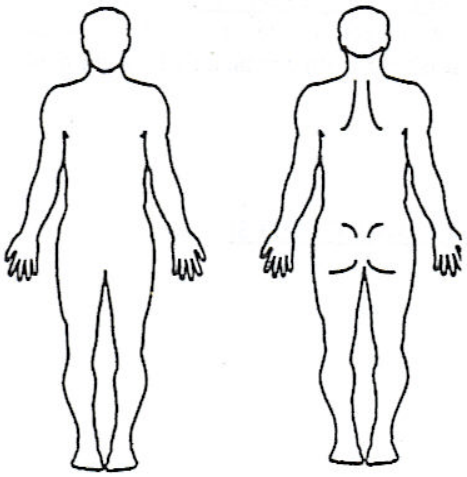
List major injuries /surgeries /hospitalizations (include dates).

_____
_____
_____

Are you pregnant? Yes No If yes, how many weeks? _____

Please circle any symptoms you have had in the last 3 months.

shortness of breath	poor appetite	anger
cough	gas/ bloating	depression
dry, sore throat	loose stools	irritability
weak voice	abdominal pain	PMS
wheezing	fatigue after eating	painful periods
difficulty taking a full breath	craving sweets	irregular cycle
frequent colds/flu	bruise easily	red eyes
allergies	weight gain	headache/migraine
runny nose	heavy sensation	stress
sinus problems	foggy thinking	bitter taste in mouth
grief, sadness	lethargy	pain below ribs
	over thinking, worry	constipation
anxiety	hemorrhoids	
panic attacks		frequent urination
palpitations	constant hunger	night urination
chest oppression	belching	sore low back
chest pain	acid reflux	weak knees
irregular heart beat	stomach ache	tooth sensitivity
mouth ulcers/cold sores	bad breath	ringing in ears
vivid dreams	toothache (without cavities)	fearfulness
nightmares	bleeding gums	hot flashes
restless sleep	mouth sores	menopause
insomnia	ulcer	impotence
		low sex drive
pain (see below)		
sharp, stabbing	tendency to feel warm	dizziness
dull, aching	flushed face/ chest	visual floaters
throbbing	tendency to feel cold	numbness/ tingling
fixed location	cold hands/ feet only	brittle nails
moving pain	night sweats	decreased night vision
affected by weather changes	spontaneous sweats (without exertion)	



Circle areas of pain
Squiggle a line over any numb areas

Is the pain
better with pressure?
worse with pressure?