

### Patient Information

**FOR OFFICE USE**

- Four-Pillar Chart
- Mandatory Disclosure
- Notice of Privacy Policy
- Letter
- Account Form

**PERSONAL** -----

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Work - \_\_\_\_\_  
Home - \_\_\_\_\_

Sex: M/F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth (D.O.B.): \_\_\_\_\_ Time of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouses Name & D.O.B.: \_\_\_\_\_

Children's' Names & D.O.B.: \_\_\_\_\_  
\_\_\_\_\_

Job Title and Responsibilities: \_\_\_\_\_

For How Long?: \_\_\_\_\_

Employer: \_\_\_\_\_

*If you wish to pay with a Visa or MasterCard, please complete the following:*

Credit Card number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Billing Zip Code: \_\_\_\_\_ Billing Street Address: \_\_\_\_\_

Three or Four Digit CVV Code (on back of card): \_\_\_\_\_

**MEDICAL** -----

Primary Healthcare Provider (PCP): \_\_\_\_\_

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

Date of Last Western Medical Examination: \_\_\_\_\_

Results & Diagnosis (if any): \_\_\_\_\_  
\_\_\_\_\_

Have you sought Western medical attention for the current complaint? Y / N

Is your PCP aware you are seeking Chinese medical treatment? Y / N

In case of emergency contact –

Name & Relation: \_\_\_\_\_

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

Please list all medications and supplements you have taken in last six months (include name, reason and length, and effects)

Name	Reason	Length	Effects

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Name	Reason	Length	Effects

Please indicate any condition you have or have had:

AIDS	Bulimia	Goiter	HIV positive	Pacemaker	Thyroid problems
Alcoholism	Cancer	Gonorrhea	Kidney disease	Pneumonia	Tonsillitis
Anemia	Cataracts	Gout	Liver disease	Polio	Tuberculosis
Anorexia	Chemical dependency	Heart disease	Measles	Prostrate problem	Typhoid fever
Appendicitis	Chicken pox	Hepatitis	Migraine headaches	Psychiatric care	Ulcers
Arthritis	Diabetes	Heart disease	Miscarriage	Rheumatic fever	Vaginal infections
Bleeding disorder	Emphysema	Hernia	Mononucleosis	Scarlet fever	Venereal disease
Breast lump	Epilepsy	Herpes	Multiple Sclerosis	Stroke	
Bronchitis	Glaucoma	High cholesterol	Mumps	Suicide attempt	

Please list all major illnesses and/or hospital stays (include date, diagnosis, treatment and outcome):

Illness/Diagnosis	Inclusive Dates	Treatment	Outcome
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Illness/Diagnosis	Inclusive Dates	Treatment	Outcome

Please give details of any problems or difficulties experienced, by you or your mother, during the nine months your mother was pregnant with you, your birth, and early childhood:

Please list family medical history, including medical conditions of parents, grandparents, and siblings:

**\* Use separate sheet if necessary.**