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ALLIANCE HEALING ARTS

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Welcome to my acupuncture and Chinese herbal medicine clinic! Please take the time to fill out this form to allow me to provide you with a more complete evaluation.

All of your answers will remain confidential. If you have any questions, feel free to ask me at any time. If there is anything you want to bring to my attention that is not listed on this form, please note it in the Comments section on the last page.

This form cannot be submitted electronically. Please print it out and bring it with you to your appointment.

Health History Questionnaire (for initial consultation)

Name		Date	
Address			
City		State	ZIP
Home Tel		Work Tel	Cell
Email			
Date of Birth		Place of Birth	
Age		Height	Weight
Occupation		Referred by	
In case of emergency, notify		Tel	
Insurance carrier		Policy #	
Have you ever been treated by acupuncture before?			
Main issue(s) you would like help with:			
How long ago did this problem begin?			
To what extent does this issue interfere with your daily activities (work, sleep, eating, etc.)?			

What kind(s) of treatment or therapy have you tried?

Past medical history (for you only, please mark the box & include dates):

- Cancer Diabetes Hepatitis High Blood Pressure Heart Disease
 Stroke Seizures Rheumatic Fever Asthma Thyroid Disease

Other significant illness (please describe):

Birth trauma (prolonged labor, forceps delivery, etc.):

Significant dental work (type and date):

Allergies (drugs, chemicals, foods, symptoms):

List any medications taken within the last two months (prescriptions, herbs, vitamins, etc.):

Describe other relevant medical history:

Family medical history (check all the boxes that apply):

- Cancer Diabetes Hepatitis High Blood Pressure Heart Disease
 Stroke Seizures Rheumatic Fever Asthma Thyroid Disease

Other relevant family medical history:

Occupational stress factors: (list physical, chemical, and/or psychological factors):

Lifestyle factors: Do you have a regular exercise program? Yes No

Please describe:

Please describe your average daily diet:

Breakfast

Lunch

Dinner

Have you ever been on a restricted diet?

Yes No

If yes, what kind?

[Text input area]

How much coffee, tea, or cola do you drink per week?

[Text input area]

Do you smoke cigarettes?

Yes No

If yes, how many per day?

[Text input area]

Do you drink alcohol?

Yes No

If so, how many drinks per week?

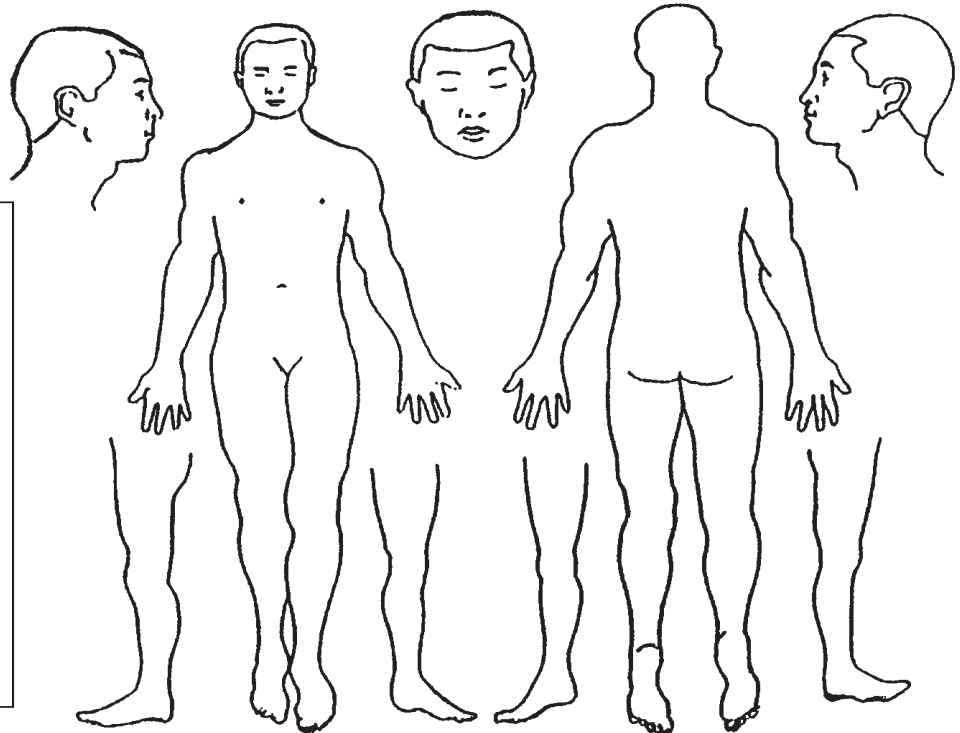
[Text input area]

Please describe any use of drugs for non-medical purposes:

[Text input area]

Please indicate painful or distressed areas. If you're filling this out on a computer, please describe the areas instead.

[Text input area]



Symbols	
Pain/pressure	X
Swelling	(
Tension	+
Weakness	-
Pulsing	*
Sore	O
Rashes	#
Spasm	→ ←
Temp. Cold	↓
Hot	↑

Indicate the degree of severity of your problem now (by marking the line):

No problem 1 2 3 4 5 6 7 8 9 10 Worst imaginable

Indicate your average energy level the past few weeks (by marking the line):

Lack desire to move 1 2 3 4 5 6 7 8 9 10 Unlimited energy all day long

Please check any symptoms you have now or have had in the past year.

Head <ul style="list-style-type: none"><input type="radio"/> Dizziness<input type="radio"/> Headaches<input type="radio"/> Migraines<input type="radio"/> Fainting<input type="radio"/> Loss of balance<input type="radio"/> Hair loss	Neck <ul style="list-style-type: none"><input type="radio"/> Lumps<input type="radio"/> Pain<input type="radio"/> Rashes<input type="radio"/> Stiffness<input type="radio"/> Swollen Glands	Ears <ul style="list-style-type: none"><input type="radio"/> Poor hearing<input type="radio"/> Ringing<input type="radio"/> Earaches<input type="radio"/> Discharge<input type="radio"/> Bleeding	Breast <ul style="list-style-type: none"><input type="radio"/> Lumps<input type="radio"/> Nipple discharge<input type="radio"/> Redness<input type="radio"/> Swelling<input type="radio"/> Tenderness/pain
Eyes <ul style="list-style-type: none"><input type="radio"/> Loss of vision<input type="radio"/> Blurry vision<input type="radio"/> Redness<input type="radio"/> Burning<input type="radio"/> Dryness<input type="radio"/> Itching<input type="radio"/> Tick/twitch<input type="radio"/> Mucous<input type="radio"/> Pain	Nose <ul style="list-style-type: none"><input type="radio"/> Bleeding<input type="radio"/> Clogged<input type="radio"/> Discharge<input type="radio"/> Loss of smell<input type="radio"/> Pain<input type="radio"/> Post-nasal drip	Mouth <ul style="list-style-type: none"><input type="radio"/> Bad breath<input type="radio"/> Bleeding gums<input type="radio"/> Dry/cracking lips<input type="radio"/> Excessive thirst<input type="radio"/> Loss of taste<input type="radio"/> Bitter taste<input type="radio"/> Sores<input type="radio"/> Tooth pain<input type="radio"/> Teeth grinding	Muscle/Joint/Nerves <ul style="list-style-type: none"><input type="radio"/> Broken bones<input type="radio"/> Difficulty walking<input type="radio"/> Muscle weakness<input type="radio"/> Stiffness<input type="radio"/> Tremors/ticks<input type="radio"/> Neck pain<input type="radio"/> Back pain<input type="radio"/> Joint pain<input type="radio"/> Muscle pain
Digestion <ul style="list-style-type: none"><input type="radio"/> Bloating<input type="radio"/> Bloody stool<input type="radio"/> Constipation<input type="radio"/> Diarrhea<input type="radio"/> Gas<input type="radio"/> Hemorrhoids<input type="radio"/> Pain<input type="radio"/> Belching<input type="radio"/> Regurgitation<input type="radio"/> Vomiting	Urination <ul style="list-style-type: none"><input type="radio"/> Blood in urine<input type="radio"/> Difficulty<input type="radio"/> Discharge<input type="radio"/> Excessive<input type="radio"/> Frequent<input type="radio"/> Scanty<input type="radio"/> Painful	Circulatory <ul style="list-style-type: none"><input type="radio"/> Calf pain<input type="radio"/> Cold feet<input type="radio"/> Cold hands<input type="radio"/> Puffy eyes<input type="radio"/> Swollen ankles<input type="radio"/> Varicose veins<input type="radio"/> Hypertension<input type="radio"/> Hypotension<input type="radio"/> Dizziness<input type="radio"/> Numbness	Neuropsychological <ul style="list-style-type: none"><input type="radio"/> Seizures<input type="radio"/> Bad temper<input type="radio"/> Lack of coordination<input type="radio"/> Depression<input type="radio"/> Easily susceptible to stress<input type="radio"/> Poor memory<input type="radio"/> Anxiety<input type="radio"/> Other
Skin <ul style="list-style-type: none"><input type="radio"/> Acne<input type="radio"/> Changing<input type="radio"/> Moles<input type="radio"/> Dry/flaky<input type="radio"/> Insect bites<input type="radio"/> Rashes<input type="radio"/> Itchy	Chest <ul style="list-style-type: none"><input type="radio"/> Cough<input type="radio"/> Pain/tight<input type="radio"/> Pressure<input type="radio"/> Palpitations<input type="radio"/> Shortness of breath	General <ul style="list-style-type: none"><input type="radio"/> Poor appetite<input type="radio"/> Insomnia<input type="radio"/> Disturbed sleep<input type="radio"/> Night sweats<input type="radio"/> Fevers<input type="radio"/> Chills<input type="radio"/> Sweat easily<input type="radio"/> Bleed/bruise easily<input type="radio"/> Strong thirst<input type="radio"/> Body temp: hot or cold	<ul style="list-style-type: none"><input type="radio"/> Thirst, but no desire to drink<input type="radio"/> Weight gain<input type="radio"/> Weight loss<input type="radio"/> Sudden energy drop<input type="radio"/> Fatigue<input type="radio"/> Cravings<input type="radio"/> Change in appetite<input type="radio"/> Chills<input type="radio"/> Poor sleep<input type="radio"/> Other

Comments: Is there anything else you want to share that was not addressed by this form?