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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?

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

Do you smoke cigarettes? ◯ Yes ◯ No

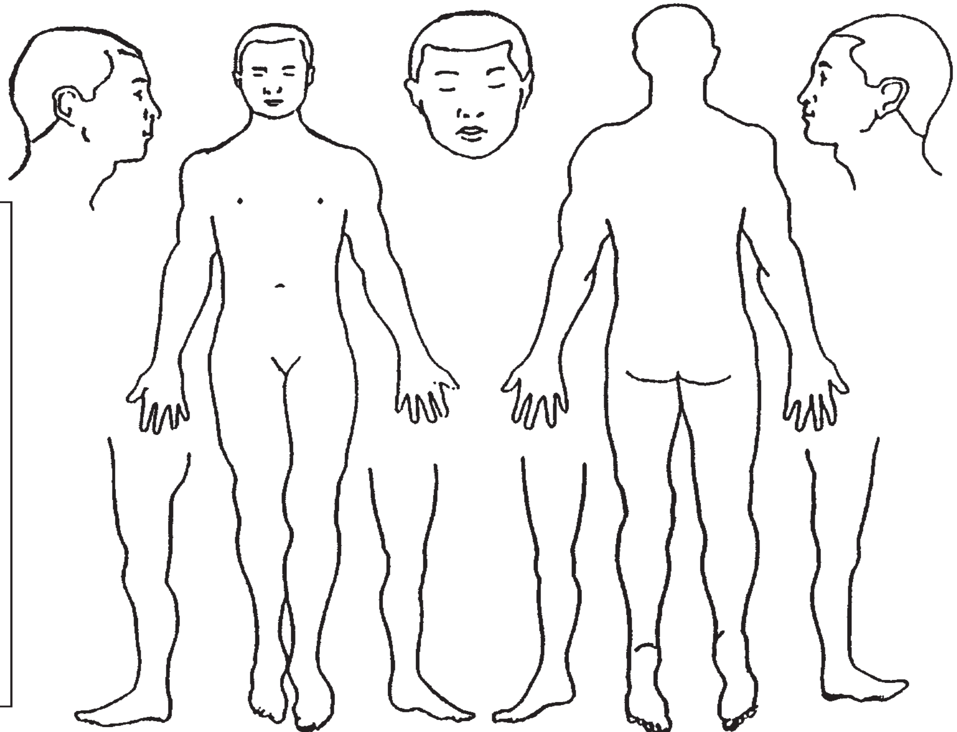
If yes, how many per day?

Do you drink alcohol? ◯ Yes ◯ No

If so, how many drinks per week?

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

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



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
- Dizziness
- Headaches
- Migraines
- Fainting
- Loss of balance
- Hair loss

Neck
- Lumps
- Pain
- Rashes
- Stiffness
- Swollen Glands

Ears
- Poor hearing
- Ringing
- Earaches
- Discharge
- Bleeding

Breast
- Lumps
- Nipple discharge
- Redness
- Swelling
- Tenderness/pain

Eyes
- Loss of vision
- Blurry vision
- Redness
- Burning
- Dryness
- Itching
- Tick/twitch
- Mucous
- Pain

Nose
- Bleeding
- Clogged
- Discharge
- Loss of smell
- Pain
- Post-nasal drip

Mouth
- Bad breath
- Bleeding gums
- Dry/cracking lips
- Excessive thirst
- Loss of taste
- Bitter taste
- Sores
- Tooth pain
- Teeth grinding

Muscle/Joint/Nerves
- Broken bones
- Difficulty walking
- Muscle weakness
- Stiffness
- Tremors/ticks
- Neck pain
- Back pain
- Joint pain
- Muscle pain

Digestion
- Bloating
- Bloody stool
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Pain
- Belching
- Regurgitation
- Vomiting

Urination
- Blood in urine
- Difficulty
- Discharge
- Excessive
- Frequent
- Scanty
- Painful

Circulatory
- Calf pain
- Cold feet
- Cold hands
- Puffy eyes
- Swollen ankles
- Varicose veins
- Hypertension
- Hypotension
- Dizziness
- Numbness

Neuropsychological
- Seizures
- Bad temper
- Lack of coordination
- Depression
- Easily susceptible to stress
- Poor memory
- Anxiety
- Other

Skin
- Acne
- Changing
- Moles
- Dry/flaky
- Insect bites
- Rashes
- Itchy

Chest
- Cough
- Pain/tight
- Pressure
- Palpitations
- Shortness of breath

General
- Poor appetite
- Insomnia
- Disturbed sleep
- Night sweats
- Fevers
- Chills
- Sweat easily
- Bleed/bruise easily
- Strong thirst
- Body temp: hot or cold
- Thirst, but no desire to drink
- Weight gain
- Weight loss
- Sudden energy drop
- Fatigue
- Cravings
- Change in appetite
- Chills
- Poor sleep
- Other

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

Women's Health History

General

Date of your last pap smear:

Have you ever had an abnormal pap smear: ◯ Yes ◯ No If yes, when?

Date of last mammogram:

Have you gone through menopause: ◯ Yes ◯ No If yes, when?

Are you currently pregnant: ◯ Yes ◯ No

No. of pregnancies: No. of miscarriages: No. of abortions:

Are you currently practicing birth control: ◯ Yes ◯ No If so, what kind?

Menstrual History

Age when you started your period: Please list the number of days in your menstrual cycle:

Please list number of days of menstrual bleeding during your cycle:

Do you have an irregular menstrual cycle: ◯ Yes ◯ No If yes, is the cycle too long, is it too short, or do you skip cycles?

Is your menstrual flow: ◯ Light ◯ Medium ◯ Heavy

Do you have bleeding or spotting in between your periods: ◯ Yes ◯ No Please describe:

Do you have menstrual cramping/pain: ◯ Yes ◯ No Please describe:

Do you have heavy bleeding during your cycle: ◯ Yes ◯ No

Do you have clotting during your cycle: ◯ Yes ◯ No

Does the following occur before or during your period?

Food Cravings:	◯ Before	◯ During	◯ N/A	Other:
Low back Pain:	◯ Before	◯ During	◯ N/A	
Night sweats:	◯ Before	◯ During	◯ N/A	
Mood Changes:	◯ Before	◯ During	◯ N/A	
Breast Tenderness:	◯ Before	◯ During	◯ N/A	
Decreased or no sex drive:	◯ Before	◯ During	◯ N/A	

Do you have or have had any of the following?

Vaginal Discharge:	◯ Currently	◯ In the past	◯ Never	Other:
Fibroids:	◯ Currently	◯ In the past	◯ Never	
Genital Sores:	◯ Currently	◯ In the past	◯ Never	
Ovarian Cyst:	◯ Currently	◯ In the past	◯ Never	
Hysterectomy:	◯ Currently	◯ In the past	◯ Never	