



Please take the time to fill out this health questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

If you need more room, please use the other side of these sheets.

## Health questionnaire

|                      |       |             |                               |
|----------------------|-------|-------------|-------------------------------|
| Name:                | _____ | Date:       | _____                         |
| Address:             | _____ |             |                               |
| City:                | _____ | State:      | _____ Zip: _____              |
| Home Phone:          | _____ | Work Phone: | _____                         |
| Mobile Phone:        | _____ | E-Mail:     | _____                         |
| Date of Birth:       | _____ | Age:        | _____ Marital Status: _____   |
| Referred by:         | _____ | Occupation: | _____                         |
| Physician:           | _____ | Phone:      | _____                         |
| Address:             | _____ | City:       | _____ State: _____ Zip: _____ |
| In Emergency Notify: | _____ | Phone:      | _____                         |



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What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

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**Personal History** Please check any conditions or symptoms you have now.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease              |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia         | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS         |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease          |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Respiratory Allergies      |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence                  |
| <input type="checkbox"/> Gastritis/Pancreatitis  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema                  |

**Family Medical History** Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes ____            | <input type="checkbox"/> Seizures ____  | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer ____        | <input type="checkbox"/> Asthma ____ |
| <input type="checkbox"/> Other _____              |   |   |                                      |

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Please **check** if you have had any of these items listed below in the last **year**  
Put a **star** on the box if you had this in the past but do not any longer.

**General**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Poor Sleeping      | <input type="checkbox"/> Fatigue                            | <input type="checkbox"/> Fevers              |
| <input type="checkbox"/> Chills                  | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Sweats Easily                      | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Cravings                | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance                       | <input type="checkbox"/> Change in appetite  |
| <input type="checkbox"/> Bleed/Bruise easily     | <input type="checkbox"/> Weight loss/gain   | <input type="checkbox"/> Peculiar tastes/smells             | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) |  |

**Skin and Hair**

- |   |                                      |  |   |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis   | <input type="checkbox"/> Itching              |
| <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Loss of hair                | <input type="checkbox"/> Recent moles         |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing        |
| <input type="checkbox"/> Dermatitis         | <input type="checkbox"/> Warts       | <input type="checkbox"/> Fungal Infection            | <input type="checkbox"/> Weak or ridged nails |

**Head, Eyes, Ears, Nose and Throat**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Difficulty swallowing        | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Glasses         |
| <input type="checkbox"/> Eye Strain           | <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness      | <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Poor hearing                 | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems  |
| <input type="checkbox"/> Nose bleeds          | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth         | <input type="checkbox"/> Facial pain     |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems              | <input type="checkbox"/> Jaw clicks/locks       | <input type="checkbox"/> Headaches       |

### Cardiovascular

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat   | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Varicose/spider veins  | <input type="checkbox"/> Pressure in chest    | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Spontaneous sweating   | <input type="checkbox"/> Dizziness            |  |

### Respiratory

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing                       | <input type="checkbox"/> Coughing blood            | <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Bronchitis              |
| <input type="checkbox"/> Pneumonia                            | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest                  | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down |  | <input type="checkbox"/> Production of phlegm... what color? _____ |  |

### Gastrointestinal

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Gas                 | <input type="checkbox"/> Belching             | <input type="checkbox"/> Black stools              | <input type="checkbox"/> Blood in stool        |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Rectal pain               | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Bloating/Edema      | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD     | <input type="checkbox"/> Hernia                    | <input type="checkbox"/> Poor appetite         |
| <input type="checkbox"/> Excessive appetite  | <input type="checkbox"/> Significant thirst   | <input type="checkbox"/> IBS/Crohn's Disease       |  |

### Genito-Urinary

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination                                    | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine          | <input type="checkbox"/> Urgent urination          |
| <input type="checkbox"/> Unable to hold urine                                 | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Scanty flow             | <input type="checkbox"/> Copious flow              |
| <input type="checkbox"/> Impotence  | <input type="checkbox"/> Sores on genitals  | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination         |
| <input type="checkbox"/> Premature ejaculation                                | <input type="checkbox"/> Decreased libido   | <input type="checkbox"/> Prostatitis             | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission                                   | <input type="checkbox"/> Pain in testicles  | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Infections                |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ |   |  | <input type="checkbox"/> Excessive libido          |

### Gynecological/Reproductive

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts              | <input type="checkbox"/> Age of first menses _____           |
| <input type="checkbox"/> Vaginal dryness               | <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Date of last menses _____           |
| <input type="checkbox"/> Vaginal sores                 | <input type="checkbox"/> Uterine Fibroids           | <input type="checkbox"/> Date of last PAP/Pelvic _____       |
| <input type="checkbox"/> Vaginal discharge             | <input type="checkbox"/> Fibrocystic breast tissue  | <input type="checkbox"/> Number of pregnancies _____         |
| <input type="checkbox"/> Infertility                   | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation        | <input type="checkbox"/> PMS                        | <input type="checkbox"/> Number of live births _____         |
|  | <input type="checkbox"/> Painful menstruation       | <input type="checkbox"/> Number of miscarriages _____        |
|  |   | <input type="checkbox"/> Number of abortions _____           |

Do you practice birth control? \_\_\_\_\_  
 What type? \_\_\_\_\_ How long? \_\_\_\_\_

### Musculoskeletal

- |                                    |  |  |  |
|------------------------------------|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel   |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica        | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain  | <input type="checkbox"/> Muscle pain     | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis      |

- Back pain Low\_\_\_ Middle\_\_\_ Upper\_\_\_       Bursitis       Rotator Cuff  
 Soreness/weakness in lower body (back, knee, hip, ankle, foot)

**Neuropsychological**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Vertigo/Dizziness            | <input type="checkbox"/> Areas of numbness           |
| <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> Poor memory          | <input type="checkbox"/> Concussion                   | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Manic Depression             |  |

- Have you ever been treated for emotional problems?       Yes     No  
 Have you ever considered or attempted suicide?       Yes     No  
 Have you ever been treated for substance abuse?       Yes     No

**Comments** Please inform me of any other problems you would like to discuss.

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## Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. \_\_\_\_\_  
initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. \_\_\_\_\_  
initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. \_\_\_\_\_  
initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. \_\_\_\_\_  
initials

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Are you Pregnant?**

\_\_\_\_\_  
**Name of Licensed Acupuncturist**

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient \_\_\_\_\_

Patient's Representative \_\_\_\_\_

Relationship or Authority of Patient \_\_\_\_\_

Witness \_\_\_\_\_

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