Acupuncture Health Questionnaire

Please print your answers.

Name_____ Date_____

Address_____ City_____ State____ Zip_____

Phone: h (_____)_____ w (_____)_____ cell (_____)_____

Please put a check mark above the phone number you wish to use for communications about appointments.

Email_____@_____

Do you wish to be on my emailing list and receive my newsletter (once or twice a month)? Yes__ No__

Referred by_____ Your primary care doctor_____

Other doctors you see_____

Date of birth_____ Age_____ Height_____ Weight_____

Occupation/position_____Employer_____

Marital status: single___ married___ living with partner___ divorced___ separated___ widowed___

No. of years married___ No. of years with partner___ No. of divorces____ Education_____

Person to contact in emergencies:_____Phone:_____

If you have children, please list ages:_____ Ages of brothers and sisters:_____

Please describe the condition you are seeking treatment for. Please provide details about how you actually experience the condition, about when it began, when and how it occurs:

_____

_____

_____

_____

Please describe all the treatments you have had for this condition, and when:

_____

_____

Please describe any emotional or lifestyle stresses you are currently experiencing

_____

_____

Review of Symptoms

	Now	Past
Back or leg pain	___	___
Neck pain	___	___
Shoulder pain	___	___
Arm pain	___	___
Elbow pain	___	___
Redness or heat in joints	___	___
Numbness	___	___
Headaches	___	___
Migraines	___	___
Dizziness	___	___
Blurred or double vision	___	___
Red, dry eyes	___	___
Ringing in ears	___	___
Canker sores	___	___
Mouth dryness	___	___

	Now	Past
Chest pain	___	___
Shortness of breath	___	___
Palpitations	___	___
Skipped beats	___	___
Chronic cough	___	___
Swollen legs	___	___
Swollen ankles	___	___
Abdominal pain	___	___
Ulcers	___	___
Sinus problem	___	___
Hoarseness	___	___
Swallowing problems	___	___
Belching	___	___

	Now	Past
Nausea	___	___
Constipation	___	___
Diarrhea	___	___
Sexual difficulties	___	___
Blood in urine	___	___
Gyn problems	___	___
Rashes	___	___
Hives	___	___
Fatigue	___	___
Feel too hot	___	___
Night sweats	___	___
Feel too cold	___	___
Very thirsty	___	___
Never thirsty	___	___

Do you have difficulty sleeping? ___No ___Yes. If yes, please describe:

_____

_____

Do you have any stomach or intestinal problems, even minor indigestion? ____No ____Yes. If yes, please describe:

_____

_____

_____

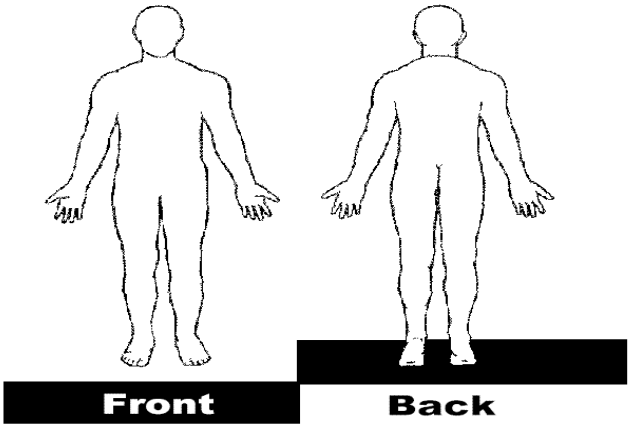
Medical History

	Now	Year
Measles	___	_____
German Measles	___	_____
Mumps	___	_____
Chicken Pox	___	_____
Scarlet Fever	___	_____
Rheumatic fever	___	_____
Polio	___	_____
Tuberculosis	___	_____
Gonorrhea	___	_____
Syphilis	___	_____
HIV positive	___	_____
AIDS	___	_____
Psoriasis	___	_____
Eczema	___	_____
Hayfever	___	_____
Asthma	___	_____

	Now	Year
Pneumonia	___	_____
Lyme Disease	___	_____
Gout	___	_____
Rheumatoid arthritis	___	_____
Osteoarthritis	___	_____
Bursitis or tendinitis	___	_____
Meningitis	___	_____
Seizures	___	_____
Kidney infection	___	_____
Bladder infection	___	_____
Prostatitis	___	_____
Gallbladder disease	___	_____
Jaundice	___	_____
Hepatitis	___	_____
Hiatal hernia	___	_____
Pleurisy	___	_____

	Now	Year
Irritable Bowel Syndrome	___	_____
Colitis	___	_____
Anemia	___	_____
Heart disease	___	_____
Hypertension	___	_____
Thyroid disease	___	_____
Diabetes	___	_____
Systemic lupus erythematosis	___	_____
Reynaud's syndrome	___	_____
Tension/migraines	___	_____
Food, chemical, or drug poisoning	___	_____
Depression, anxiety	___	_____
Cancer	___	_____

Please indicate on the drawings below any areas of discomfort, pain, or tension, including all areas to which the pain radiates. Please use the following codes: N = numbness. T = tingling. D = dull pain. P = sharp pain. B = burning. S = stiffness.



Please use the following scale to describe your pain:

No pain *Distressing Pain* *Unbearable Pain*

/_____/_____/_____/_____/_____/_____/_____/_____/_____/_____/

0 1 2 3 4 5 6 7 8 9 10

What is the duration of the pain , i.e. how often and for how long? _____

What makes these symptoms decrease?_____

What makes them increase?_____

Please list all surgeries you have had:_____

_____

Please list all your
hospitalizations:_____

_____

Please list all medications you are taking:
_____

_____

Please list all herbs and nutritional supplements you are taking:_____

_____

Your usual blood pressure:_____/_____ Total cholesterol_____

If you have allergies, including drug or food allergies, please list: _____

Women only:

Are you pregnant?_____ Are you taking birth control pills?_____
Are you past menopause? yes___ no___ If you are taking hormones, what kind?_____
Please describe your periods. If you are past menopause, please describe them as they generally used to be.

Cramping:	none ___	a little ___	a lot ___
Clotting:	none ___	a little ___	a lot ___
Bleeding:	light ___	moderate ___	heavy ___
Depression	none ___	a little ___	a lot ___
Irritability	none ___	a little ___	a lot ___
Anxiety	none ___	a little ___	a lot ___
Breast tenderness	none ___	a little ___	a lot ___
Increase in other pain:	none ___	a little ___	a lot ___
Frequency :	regular___, occurring every _____ days		
	irregular, ___, occurring between _____ and _____ days		

How many childbirths?_____ How many Caesarean sections? ___

Nutrition and Lifestyle

Please describe – ***in as much detail as possible -*** what you typically eat, and how much:

1.Breakfast
(time:_____am)_____

2. Lunch
(time:_____am/pm)_____

3. Snacks
(time:_____pm)_____

4. Dinner
(time:_____pm)_____

Do you have cravings for sugar and sweets? ___ yes ___ no
Do you have cravings or strong urges for salt? ___ yes ___ no
Do you overeat? __ no ___ sometimes ___ often
Do you smoke? ___ no ___ yes , since_____(year); ___ used to, but stopped_____ years ago
If yes, what brand?_____ Number of packs per day_____
How many alcoholic drinks do you have in a week?___ beer ___ wine ___liquor
How many cups of coffee per day? ___ regular ___ decaffeinated
How many sodas per week? ___ check the following if they apply: ___ regular ___ caffeinated __ diet
How much water per day? ___ cups
On the average, how many hours of sleep do you get at night?___

Please describe the type, amount, and frequency of exercise you do:

1._____ for _____ hrs._____ mins, _____ times per week
2._____ for _____ hrs._____ mins, _____ times per week
3._____ for _____ hrs._____ mins, _____ times per week