Healing With Grace

Acupuncture & Chinese Herbalism

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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you.

Personal Information

Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____ Email Address: _____

Emergency Contact: _____ Phone: _____

How did you hear about our office? Whom may we thank for referring you? _____

Medical Information

Sex: _____ Height: _____ Weight: _____ Birth Date: _____ Age: _____

Relationship Status: _____ Do you have children? ☐ yes ☐ no If yes, how many? _____

Previous Acupuncture? ☐ yes ☐ no When? _____ With Whom? _____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____

(What? _____)

Sexually Transmitted Diseases: (When? _____)

☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffee/black tea:	☐	☐	_____	Tobacco:	☐	☐	_____	Water:	☐	☐	_____
Recreational drugs:	☐	☐	_____	Alcohol:	☐	☐	_____	Soda pop:	☐	☐	_____

Please Check the Box if any of the following statements are true:

I have known allergies: ☐ Yes ☐ No They are: _____

I am taking Coumadin / Warfarin / Plavix: ☐ Yes ☐ No

I have a pacemaker: ☐ Yes ☐ No

I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs): ☐ Yes ☐ No

Physician History

Have you seen a physician in the last year? ☐ Yes ☐ No If yes, for what reason: _____

Physician's name: _____ Phone: _____

At which hospital or birth center will you be giving birth? _____

Medications

Please list any prescription or OTC medications or supplements and herb you are currently taking:

Rx/Supplement/Herb	Dosage	Reason for taking the item:	For how long?	Prescribed by whom?	Date of last check-up?

(Please attach a list if you have additional medications/supplements)

Initial Consultation

What are the main health problems for which you are seeking treatment? _____

List any allergies, food sensitivities, or food cravings that you have: _____

What other forms of treatment have you sought? _____

List any accidents, surgeries, or hospitalizations (include date): _____

List any other health problems you now have: _____

Lab results (please bring/send copies): _____

How would you classify your condition?

□ Minor □ Involved □ Severe/Worsening □ Serious

How do you feel about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments:
Spouse/ SO	□	□	□	□	□	_____
Family	□	□	□	□	□	_____
Diet	□	□	□	□	□	_____
Sex	□	□	□	□	□	_____
Self	□	□	□	□	□	_____
Work	□	□	□	□	□	_____
Exercise	□	□	□	□	□	_____
Spirituality	□	□	□	□	□	_____

Age when 1st menses began (menarche): _____ Age when menses ceased (menopause): _____

Are you pregnant? □ Yes □ No # Pregnancies: _____ Live Births: _____ Abortions: _____ Miscarriages: _____

Date of last: GYN exam _____ Pap Smear _____ Mammogram _____ Bone Density Scan _____

Results: _____

Number of days in cycle (from start of menses to start of next): _____ Are clots present? □ Yes □ No

Number of days of menstrual blood flow: _____ Color of menstrual blood: _____

Number of pads/tampons/mL per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ 5th day _____

Have you been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts □ PID

□ Other _____

Location of Menstrual Pain: □ Lower abdomen □ Lower back □ Thighs □ Other _____

Nature of Pain & When (BEFORE, DURING, or AFTER menses):

Cramping: _____ Stabbing: _____ Burning: _____ Aching: _____ Dull: _____

Bloating: _____ Consistent: _____ Intermittent: _____ Bearing down sensation: _____

Other symptoms related to menses:

□ Discharge □ Vaginal dryness □ Headache □ Increased libido

□ Nausea □ Constipation □ Diarrhea □ Decreased libido

□ Swollen breasts □ Mood swings □ Ravenous appetite □ Insomnia

□ Poor appetite □ Hot flashes □ Night sweats

For Men

Date of last prostate check-up: _____ Results: _____

Lab results: _____

Frequency of urination: (*daytime*) _____ (*nighttime*) _____ Is there strong odor? □ Yes □ No

Color of Urine: _____ □ Clear □ Murky

Symptoms related to prostate:

□ Prostate problems □ Delayed stream □ Dribbling □ Retention of Urine □ Incontinence

□ Rectal dysfunction □ Increased libido □ Decreased libido □ Premature ejaculation □ Impotence

□ Back pain □ Groin pain □ Testicular pain □ Pain with Urination □ Infertility

Symptom Survey (for Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

check mark (✓) = sometimes experience **plus sign (+)** = frequently experience

__ fatigue
__ edema
__ blood in stool
__ black tarry stool
__ easily bruised
__ difficult to stop bleeding
__ asthma
__ catch colds easily
__ intolerance to weather changes
__ allergies
__ hay fever
__ dizziness
__ tendency to faint
__ high cholesterol
__ sudden weight loss

__ insomnia, difficulty sleeping
__ night sweats
__ heart palpitations
__ cold hands & feet
__ nightmares
__ mentally restless
__ laughing for no apparent reason
__ angina pains
__ abdominal pain
__ chest pain
__ sciatic pain
__ headaches
__ pain or coldness in the genital area

__ cough
__ short of breath
__ decreased sense of smell
__ sinus congestion
__ nasal problems
__ skin problems
__ feeling of claustrophobia
__ bronchitis
__ colitis or diverticulitis
__ constipation
__ hemorrhoids
__ recent or recurrent use of antibiotics

__ lack of appetite
__ excessive appetite
__ loose stool or diarrhea
__ flatulence
__ belching, burping
__ heartburn/reflux
__ halitosis
__ digestive problems, indigestion
__ feeling retention of food in the stomach
__ vomiting, nausea
__ tendency to become obsessive in work, relationships …

__ eye problems
__ jaundice (yellowed eyes or skin)
__ difficulty digesting oily foods
__ gall stones
__ light-colored stool
__ soft or brittle nails
__ easily angered or agitated
__ difficulty making plans or decisions
__ spasms or muscle twitching

__ low back pain
__ knee problems
__ impaired hearing
__ ringing in the ears
__ kidney stones
__ decrease sex drive
__ hair loss
__ urinary problems