Health and Vision Acupuncture Center

This is a confidential questionnaire to help determine the best treatment plan for you. If you have any questions, please ask. Thank you.

Personal Information

Name_____ Today's Date_____
Home Address_____
City _____ State _____ Zip _____
Home Phone_____ Cell Phone_____ Work Phone_____
Email address _____
Occupation_____ Person responsible for account_____
Sex __Male __Female Height _____ Weight _____ Birthdate _____ Age _____
Marital Status __Married __Single __Divorced __Widowed Number of Children_____
Have you ever had Acupuncture before? ___Yes ___No
When_____ With Whom? _____

Primary Care Physician Name _____ Phone _____
Primary Care Clinic _____
Address _____

Please indicate any significant illnesses you are a blood relative (Grandparent, parent of sibling) have had:

Illness	You	Relative	Approx Date	Illness	You	Relative	Approx Date
Cancer				Diabetes			
Hepatitis				Heart Disease			
High Blood Pressure				Seizures			
Rheumatic Fever				Emotional Disorders			
Infectious Diseases				Tuberculosis			

Sexually Transmitted Diseases __ Gonorrhea __ Syphilis __ AIDS __HPV __HIV __ Chlamydia __ Herpes
Date _____

Please list any medications you are currently taking (continue on back if necessary)

Medicine	Dosage	Reason	How Long?	Prescribed by	Date last check up

Please indicate the use and frequency of use of the following:

Substance	Yes	No	How much? How often?	Substance	Yes	No	How much? How often?
Coffee/Black Tea				Tobacco			
Non-Medical Drugs				Alcohol			
Over the Counter Drugs				Water			
				Soda			

Medical History

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

_____

_____

_____

What other forms of treatment have you sought? _____

_____

_____

_____

List any health problems you now have: _____

_____

_____

_____

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

_____

_____

_____

List any accidents, surgeries, or hospitalization (include dates): _____

_____

_____

_____

Lab results: (please include copies)_____

_____

_____

_____

How do you feel about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

Area	Great	Good	Fair	Poor	Bad	Comments
Significant Other						
Family						
Diet						
Self						
Work						
Exercise						
Spirituality						

Additional Notes: _____

_____

_____

_____

_____

_____

_____

Patient Name: _____

For Females Only

Are you pregnant? __Yes __No ___ # of pregnancies _____
# of live births ___ # of abortions ___ # of miscarriages _____
Please indicate the last date of the following:
Gynecological exam _____ Pap Smear _____
Mammogram _____ Bone Density Scan _____
Results of each: _____
_____
_____
Age of first period (menarche) _____Age of last period (menopause) _____
Number of days between periods _____Number of days of flow _____
Color of flow _____ Clots? __ Yes __ No Color of clots _____
Average number of pads you use per day ___1st day ___2nd day ___3rd day___4th day ___5th and greater
Any main with menstruation? ____ Yes ___ No
Location if pain, if any: ___ Lower abdomen ___ Lower Back ___ Thighs | List other locations _____
_____

Nature of pain					**Other symptoms related to menstruation**							
Cramping		Stabbing		Discharge		Vaginal dryness		Headache	
Burning		Aching		Nausea		Constipation		Diarrhea	
Dull		Bloating		Swollen Breasts		Mood Swings		Ravenous Appetite	
Consistent		Intermittent		Poor Appetite		Hot Flashes		Night Sweats	
Bearing down sensation				Increased Libido		Decreased Libido		Insomnia	

For Males Only

Please indicate the last date of the following:
Prostate check-up date: _____
PSA exam: ___ Yes ___ No PSA Results: _____
Manual prostate exam: ___ Yes ___ No Results: _____
Lab results _____
Frequency of urination Daytime:_____ Nighttime: _____
Color of urine: ___ Clear ___ Murky ____ Strong Odor

Please indicate all symptoms									
Prostate Problems		Delayed Stream		Dribbling		Incontinence		Retention of Urine	
Rectal Dysfunction		Increased Libido		Decreased Libido		Premature Ejaculation		Impotence	
Back Pain		Groin Pain		Testicular Pain		Pain with Ejaculation			

Other problem: _____
_____
_____

Patient Name: _____

Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no marks = never experience check mark = sometimes experience plus sign (+) = frequently experience

__ lack of appetite
__ excessive appetite
__ loose stool or diarrhea
__ digestive problems, indigestion
__ vomiting
__ belching, burping
__ heartburn/reflux
__ feeling the retention of food in the stomach
__ tendency to become obsessive (work, etc.)
__ insomnia
__ heart palpitations
__ cold hands and feet
__ nightmares
__ mentally restless
__ laughing for no apparent reason
__ angina pains
__ abdominal pains
__ chest pain
__ sciatic pain
__ headaches
__ pain or coldness in the genital area
__ cough
__ shortness of breath
__ decreased sense of smell
__ nasal problems
__ feeling of claustrophobia
__ bronchitis
__ colitis or diverticulitis
__ constipation
__ hemorrhoids
__ recent use of antibiotics
__ eye problems
__ jaundice (yellowish eyes of skin)
__ difficulty digesting oily foods
__ spasms or twitching of muscles
__ gall stones
__ light colored stool
__ soft or brittle nails
__ easily angered or agitated
__ difficulty in making plans or decisions
__ low back pain
__ knee problems
__ hearing impairment
__ ear ringing
__ kidney stones
__ decreased sex drive
__ hair loss
__ urinary problems
__ fatigue
__ edema
__ blood in stool
__ black tarry stool
__ easily bruised
__ difficult to stop bleeding
__ asthma
__ tendency to catch colds easily
__ intolerance to weather changes
__ allergies
__ hay fever
__ dizziness
__ tendency to faint easily
__ high cholesterol levels

Patient Name: _____

Notes:

Patient Name: ____