Acupuncture and Herbal Medicine Healthcare
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This is a CONFIDENTIAL questionares to help us determine the best treatment plan for you. If you have questions, please ask.

Personal Information

Name _____
Last Name First Nam Middle Initial

Home Address _____

City _____ Statre _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SSN _____

Energency Contact: Name _____ Phone _____

Current Physician Name _____ Phone _____

Date Of Birth (mm/dd/yyyy) _____ Age _____ Birth Place _____

Sex ☐ Male ☐ Female ☐ Trans MTF _____ FTM _____ Height _____ Weight

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Occupation ☐ Employed Employer Name _____

☐ Student ☐ Full Time ☐ Part Time

Who should we thank for referring you to this office? _____

Have you received acupuncture therapy before? ☐ Yes ☐ No
If yes When? _____ For? _____ With Whom? _____

Have you taken herbal medicine before? ☐ Yes If yes ☐ Patent ☐ Raw ☐ Granule

If your insurance plan doesn't cover acupuncture, please skip this page.

Insurance Information

Insured's I.D. Number _____

Insured's Name (if different than the patient) _____
Last Name First Name Middle

Insured's SSN

If different than the patient, patient reltionship to the insured

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Insured's Policy Group or FECA Number _____

Insured's Date Of Birth (mm/dd/yyyy) _____ Sex ☐ Male ☐ Female

Employer's Name _____

Insurance Plan Name or Program Name

Is there another health insurance plan? ☐ Yes ☐ No

If Yes

Other Insured's Name _____
Last Name Frist Name Middle

Other Insured's Policy Group or FECA Number

Insured's Date Of Birth (mm/dd/yyy) _____ Sex ☐ Male ☐ Female

Employer's Name _____

Insurance Plan Name or Program Name _____

Health Information

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

Illness	You	Your Relative	Aprox. Date		You	Your Relative	Aprox. Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizure	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Tuberculosis	☐	☐	_____
Gonorrhea	☐	☐	_____	HIV	☐	☐	_____
Syphilis	☐	☐	_____	HPV	☐	☐	_____
Herpes	☐	☐	_____	Chlamydia	☐	☐	_____

Please indicate if any of the following pertain to you:

☐ Low Blood Pressure ☐ Pregnancy ☐ Strep Infection ☐ Latex Allergy ☐ Faint

☐ Lymph Node Removed ☐ Alcoholism ☐ Birth Trauma ☐ Lyme disease ☐ MS

☐ Blood-Thinning Meds ☐ Pacemaker ☐ Asthma ☐ Other Allergy: To What? _____

☐ Coumadin/Warfarin or similar medication

☐ Lithium (Eskalith, Lithobid, Lithinate, Lithotabs)

Other Major Illness, Injuries, Surgeries, Hospitalization, Cosmetic work:
Please provide details: _____
When? (Date) _____

List any medications and supplements you are currently taking:

Medicine	Illness	Dosage	How Long	Prescribed By	Date of Last Checkup
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

For Women Only

of pregnancies ____ # births ____ # premature births ____ # miscarriages ____ # abortions ____
Age of 1st menses ____ # days between menses ____ Duration of menses ____
Age of menopause ____ Date of last PAP ____

☐ Painful Periods ☐ Irregular Periods ☐ Slight periods ☐ Heavy periods

Color	Day	Amount	Day	# of Pad	
☐ pale/light red	____	☐ heavy	____	1st	____
☐ red	____	☐ light	____	2nd	____
☐ bright red	____	☐ even	____	3rd	____
☐ dark red	____	☐ heavy	____	4th	____
☐ dark red/brown	____	☐ clots	____	day+	____

Pain/Cramping ☐ yes ☐ no
Location ____
Nature of Pain
☐ Stabbing ☐ Consistent
☐ Cramping ☐ Intermitten
☐ Buring
☐ Dull
☐ Bearing Down

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Nipple Discharge ☐ Infertility ☐ Other: ____

Do you practice birth control? ☐ yes ☐ No What type and for how long? ____

For Men Only

Date of last prostate check up ____ PSA results ____
Lab results ____
Frequency of urination: Daytime ____ Nighttime ____ Color of urine: ☐ Clear ☐ Murky

Symptoms related to the prostate:

☐ Prostate Problems	☐ Delayed Stream	☐ Dribbling	☐ Incontinence	☑ Retention of Urine
☐ Rectal Dysfunction	☐ Increased libido	☐ Decreased libido	☐ Impotence	☐ Premature Ejaculation
☐ Back Pain	☐ Groin Pain	☐ Testicular Pain	☐ Other ____	

Overall Life Satisfaction

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

	Great	Good	Fair	Poor	Bad	Your comments
Significant other	☐	☐	☐	☐	☐	____
Family	☐	☐	☐	☐	☐	____
Diet	☐	☐	☐	☐	☐	____
Sex	☐	☐	☐	☐	☐	____
Work	☐	☐	☐	☐	☐	____
Exercise	☐	☐	☐	☐	☐	____
Spiritual	☐	☐	☐	☐	☐	____

Diet

Food cravings: _____

Food intolerance: _____

How much do you consume (servings per day/week) if tracked with 7 days food journal

Meat _____ Sugar/Sweets _____ Dairy Products _____

Do you prefer drinks ☐ Hot ☐ Room Temperature ☐ Cold

Taste Preference: ☐ Salty ☐ Spicy ☐ Sweet ☐ Sour ☐ Bitter

Do you eat three meals on regular schedules? When

Breakfast ☐ yes ☐ no _____
Lunch ☐ yes ☐ no _____
Dinner ☐ yes ☐ no _____

Please indicate the frequency and amount of the following:

	Coffee	Tea	Tobacco	Alcohol	Non-medical drugs	Soda pop	Water
Yes	☐	☐	☐	☐	☐	☐	☐
No	☐	☐	☐	☐	☐	☐	☐
How much	_____	_____	_____	_____	_____	_____	_____

Activities & Sleep

What do you do for fun? _____

Do you exercise regularly? ☐ yes ☐ no If yes, what type? _____

What time do you usually go to sleep? _____

How many hours do you usually sleep? _____

Do you have hard time to fall in sleep? ☐ yes ☐ no

Do you wake up and have hard time fall back to sleep? ☐ yes ☐ no

Do you have hard time to get up? ☐ yes ☐ no

SYMPTOM SURVEY (FOR EVERYONE)

The following is a list of symptoms that you may or may not have ever experienced.
Please indicate as follow: blank = never experience ; check = sometimes experience; plus sign (+) = frequently experience

General
- Recurrent Infections
- Night Sweats
- Spontaneous Sweat
- Bleed or bruise easily
- Thirst with no desire to drink
- Fatigue
- Sudden energy drops
  - Time of day _____
- Poor Sleep
- Poor Balance
- Edema

Skin
- Rashes
- Itching
- Eczema
- Oozing
- Pimples
- Dry skin / scalp
- Other _____

Cardiovascular
- Chest discomfort/pain
- Heart Palpitations
- Cold hands or feet
- Swelling of hands or feet
- Blood Clots
- Spider veins
- Other _____

Respiratory
- Difficulty breathing
- Shortness of breath
- Recurrent cough
- Asthma/Wheezing
- Production of phlegm
  - color _____
- Bronchitis
- Pneumonia
- Other _____

Digestion
- Bad breath
- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- Acid Reflux
- Other _____

- Abdominal pain or cramps
- Weight gain
- Weight loss
- Loose stools / Diarrhea
- Strong smelling stools
- Bloody tarry stools
- Pale stools
- Green stools
- Black stools
- Constipation
- Gas
- Rectal pain
- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Other _____

Head/Eyes/Ears/Nose/Throat
- Headache
- Frontal/Sinus headche
- Vertex headache
- Migraines headache
- Discharge from ear
- Poor hearing
- Ringing in ears
- Blurry vision
- Night blindness
- Color blindness
- Floaters
- Eye pain
- Excessive tearing
- Glasses
- Facial pain
- Nose bleeds
- Nasal discharge
- Blocked nose
- Snoring
- Grinding teeth
- Teeth/Gum problems
- Recurrent sore throat
- Hoarseness
- Tonsillitis
- Swollen glands
- Sores on lips/mouth
- Other _____

Genito-Urinary
- Pain in urination
- Urgency with urination
- Frequent urination
- Other _____

- Blood in urine
- Decrease in urinary flow
- Unable to hold urine
- Incontinence at night
- Dribbling urination
- Kidney stones
- Impotency
- Changes in sexual drive
- Rashes
- Do you wake at night to urinate?
  - How many times?_____
- Other _____

Musculoskeletal
- Neck ache/pain
- Back ache/pain
- Knee ache/pain
- Shoulder pain
- Elbow/Forearm pain
- Hand/Wrist pain
- Foot/Ankle pain
- Joint/Bone problems
- Torn tissues
- Prostheses
- Muscle pain/weakness
- Hernia
- Other _____

Neurological
- Seizures
- Nerve damage
- Paralysis
- Stroke
- Sleep disorder
- Concussion
- Vertigo
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty in concentrating
- Other _____

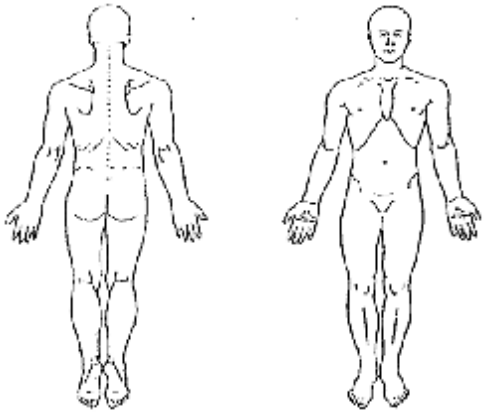
Behavioral
- Vacant
- Moody
- Easily susceptible to stress
- Aggressive/Bad temper
- Lose control of emotions
- Anxiety
- Panic attacks
- Depression
- Fear
- Other _____

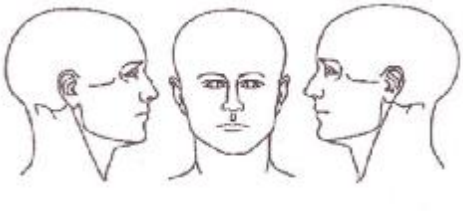
Sympton Survey (For Everyone) - Continue

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

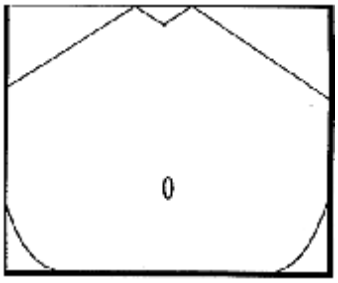
What other treatments have you tried?

Place an 'X' on where you experience pain in the body and head





Place an 'X" on where you experiece pain, distention or discomfort on abdominal



Patient's Signature _____ Date _____