NEW PATIENT HEALTH HISTORY

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Acupuncture and Herbs

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. If there is anything you wish to bring to my attention which is not asked on this form, please write it in the Comments Section. I encourage you to respond to as many questions as you are comfortable with, as it will help us to together get a clear perspective on your overall health.
Some sections of this form are quite personal. All information will be held in the strictest confidence.

Name____Date______________________

Address ____

City_______________________State___________________ Zip Code_________________

Phone (H)___________________ (W)____________________ (Mobile)_________________

Email_______________________ @______________________DOB______________________

May I leave a message if you are unavailable? Yes____No_____Referred By________________

In Case of Emergency Contact ____

Physician Name ____

Physician Phone________________________ May I contact your physician? Yes_____ No____

Physician Address____

Insurance Company______________________ Policy Number__________________________

Main Reason For Seeking Acupuncture____

____

How long ago did this problem begin?____

To what extent does this problem interfere with daily activities, work, sleep, sex? _____________

____

Have you been given a diagnosis for this problem? If so, what? ___________________________

____

What kinds of treatments have you tried to address this problems?_______________________

____

What helps this condition improve? (Rest, exertion, heat, cold, etc)________________________

What aggravates this condition?____

Past Medical History (Please Include Dates)

Significant Illnesses Cancer Diabetes Hepatitis High Blood Pressure VD HIV EBV Heart Disease Rheumatic Fever Thyroid Disease Seizure Auto Immune Disease Other

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____

Surgeries (list dates)______________________________________

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____

Significant Traumas (accidents, falls, etc.)______________________________

____

Do you have any scars?__________ **Where?**______________________________

Birth History (premature birth, health complications, forceps delivery, etc.)____________

Allergies (drugs, chemicals, foods, seasonal)______________________________

____

Family Medical History Cancer Diabetes High Blood Pressure Mental Illness Seizures Alcoholism Heart Disease Asthma Allergies Auto Immune Disease Stroke Arthritis

Other____

Medications taken within the last 2 months (vitamins, herbs, homeopathics, etc)__________

____

____

Have you ever had steroid injections? Cortisone?______________________________

Occupational Stress (physical, chemical, psychological)__________________________

Do you exercise regularly?__________ Describe______________________________

____

Are you on a restricted diet?____________________________________

Please describe an average day's meals______________________________

Morning____

Afternoon____

Evening____

Do you smoke, chew or snuff tobacco?_________ If so, how much?__________________

How much tea, coffee or soda do you drink per week?__________________________

How much alcohol do you drink per week?______________________________

Do you use any medications or drugs for non-medical reasons?____________________

Emotional Health: Rate the frequency with which you experience the following emotions (1=never, 2=occaisionally, 3=frequently, 4=regularly)

_____Grief	_____Sadness	_____Depression	_____Worry	_____Anxiety
_____Anger	_____Irritability	_____Obsession	____Pensiveness	_____Fear

Cravings

_____sweet	_____sour	_____bitter	_____spicy	_____dairy
_____raw	_____fried	_____salty	_____hot	_____cold

Please Check if you have had in the last 3 months:

General

_____Poor Appetite	_____Poor Sleep	_____Fatigue
_____Fevers	_____Chills	_____Night Sweats
_____Sweat Easily	_____Tremors	_____Cravings
_____Localized Weakness	_____Poor Balance	_____Change in Appetite
_____Bleed or Bruise Easily	_____Weight Loss	_____Weight Gain
_____Peculiar Tastes or Smells	_____Sudden Loss of Energy	_____Strong Thirst
	What time?_________	Hot or Cold Drinks?

Skin and Hair

_____Rashes	_____Ulcerations	_____Hives
_____Itching	_____Eczema	_____Pimples
_____Dandruff	_____Hair Loss	_____Moles

_____Any other changes in hair or skin (texture, color, etc.)?________________________________

Cardiovascular

_____High Blood Pressure	_____Low Blood Pressure	_____Chest Pain
_____Irregular Heart Beat	_____Dizziness	_____Fainting
_____Cold Hands or Feet	_____Swelling of Hands	_____Swelling of Feet
_____Blood Clots	_____Phlebitis	_____Difficulty in Breathing
_____Varicose Veins	_____Vascular Spiders	_____Palpitations

_____Other____

Head, Eyes, Ears, Nose and Throat

_____Dizziness _____Concussions _____Migraines

_____Glasses _____Eye Strain _____Eye Pain

_____Poor Vision _____Night Blindness _____Color Blindness

_____Cataracts _____Blurry Vision _____Ear Aches

_____Ringing in Ears _____Poor Hearing _____Spots in front of Eyes

_____Sinus Problems _____Nose Bleeds _____Recurrent Sore Throats

_____Teeth Problems _____Jaw Clicks _____Bleeding Gums

_____Grinding Teeth _____Facial Pain _____Sores on Lips or Tongue

_____Headaches? Where in head and what time of day?_______________________________________

_____Any other head or neck problems?____

Respiratory

_____Frequent Colds _____Cough _____Asthma

_____Bronchitis _____Pneumonia _____Shortness of Breath

_____Pain with a deep breath _____Tightness of Chest _____Wheezing

_____Production of Phlegm (what color?)____

_____Other Lung Problems____

Gastrointestinal

_____Nausea _____Vomiting _____Diarrhea

_____Constipation _____Gas _____Belching

_____Black or Bloody Stools _____Ulcers _____Indigestion

_____Bad Breath _____Rectal Pain _____Hemorrhoids

_____Abdominal Cramps _____Bloating After Eating _____History of Parasites

_____Chronic Laxative Use _____Constant Hunger _____Heartburn

_____Other Stomach or Intestinal Problems____

Genito-Urinary

_____Pain with Urination _____Frequent Urination _____Blood in Urine

_____Wake to Urinate _____Unable to Hold Urine _____Kidney Stones

_____Genital Itching _____Impotency _____Sores on Genitals

_____Low Sex Drive _____Prostate Problems _____Infertility

_____Other____

Reproductive and Gynecologic

_____Number of Pregnancies _____Number of Births _____Premature Births

_____Miscarriages _____Abortions _____Age at First Menses

_____Date of Last Menses _____Last PAP Date _____Age at Menopause

_____Absence of Period _____Painful Periods _____Irregular Periods

_____Excess Facial Hair _____Vaginal Discharge _____Breast Lumps

_____Vaginal Sores _____Infertility _____PMS

_____Endometriosis _____Fibroids _____Cysts

_____Other____

____

Do you practice birth control?_________What type and for how long?_________________________

Have you ever taken the birth control pill or estrogen replacement therapy?__________________

Are you currently sexually active?____________With men____________With women___________

Any complications during pregnancy or in labor?____

Menstruation

Please describe your menstrual cycle including the following information, be specific:

How long do you bleed?___________________How heavy?___________________________________

Cramping? Describe: Before________________During_______________After__________________

____

Color of blood at Beginning________________Middle_______________End____________________

Clotting size and color____________________Breast Tenderness?____________________________

Bloating?________________________________Headaches?__________________________________

Length of cycle (no. of days from Day 1 of bleeding to beginning of next cycle)________________

Emotional sensitivities before, during or after menstruation?_________________________________

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Have there been any notable changes in your period in the last 6-12 months?__________________

Menopause, are you Peri-Menopausal?_______Menopausal?___________Post?_________________

Describe:____

____

Additional information:____

____

____

____

____

Musculoskeletal

_____Neck Pain _____Shoulder Pain _____Hand or Wrist Pain

_____Back Pain _____Hip Pain _____Knee Pain

_____Foot Pain _____Muscle Pain _____Muscle Weakness

_____Any other joint, muscle or bone problem?____

Neuropsychological

_____Seizures _____Dizziness or Vertigo _____Loss of Balance

_____Areas of Numbness _____Lack of Coordination _____Poor Memory

_____Concussion _____Depression _____Anxiety

_____Bad Temper _____Irritability _____Easily stressed

_____Other?____

Personal

Are you currently experiencing any significant family stress?_________________________________

In the past year have you experienced any significant loss?______Death of a loved one or pet, job loss, miscarriage, divorce or separation, etc?____

Do you feel actively supported by your family and friends?__________________________________

Do you live alone?_______________Do you own pets?______________________________________

Do you consider your home life to be stressful?____

Do you consider your work life to be stressful?____

Please feel free to add any other information you would like to discuss_______________________

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Thank you for taking the time and energy to help us help you.