The following is a confidential questionnaire to determine the best possible treatment plan for you. Please take your time in completing the information. THANK YOU!

****

A. PERSONAL INFORMATION:

NAME ___________________________________(FIRST)
(LAST)_________________________________(MIDDLE)_______________________

ADDRESS____
_______________CITY_____________STATE__________________ZIP

PHONE #s HOME ( ) ______________________________
WORK ( ) ______________________________
CELL ( ) ______________________________

BIRTH DATE: ____________________

Marital Status: ( ) Married ( ) Single

EMPLOYER____

SPOUSE'S: Only if under spouse's insurance plan.
NAME_______________________________ S.S. # ______________________
EMPLOYER____

WHO REFERRED YOU TO OUR OFFICE?

____

HAVE YOU BEEN TREATED BY AN ACUPUNCTURIST BEFORE? IF SO, PLEASE GIVE THE NAME OF THE DOCTOR:

____

** CONTINUE PLEASE **

B. MEDICAL HISTORY

HEIGHT__________________________ WEIGHT__________________________

WHEN WERE YOU LAST SEEN BY A PHYSICIAN? ________________________________
REASON FOR THE VISIT____
NAME OF THE PHYSICIAN______________________ TEL # ____________________

PLEASE INDICATE ANY HOSPITALIZATIONS YOU HAVE HAD:
1.______________________________________ (DATE)___________________
2.______________________________________ (DATE)___________________

PLEASE DESCRIBE THE REASON(S) FOR VISITING THIS OFFICE:
____
____
____

PLEASE INDICATE OTHER HEALTH PROBLEMS YOU HAVE, IF ANY:
____
____

C. YOUR HEALTH INFORMATION

IS THERE A HISTORY OF CANCER, TUBERCULOSIS, OR DIABETES, ETC. IN YOUR FAMILY? _____
IF YES, WHO____
WHAT ILLNESS____

HAVE YOU EVER BEEN DIAGNOSED WITH HIV OR HEPATITIS B/C?_____________________

PLEASE LIST ANY PRESCRIBED MEDICINE(S) THAT YOU ARE PRESENTLY TAKING, W/DOSAGE:
____
____
____
____
HOW OFTEN DO YOU DRINK TEA, COFFEE OR ALCOHOL?
____
HOW OFTEN DO YOU EXERCISE? ____

FOR WOMEN ONLY: ARE YOU PREGNANT? ____HOW MANY BIRTHS? ( )
MISCARRIAGES? ( )
PLEASE INDICATE THE RESULTS OF YOUR LAST GYNECOLOGICAL EXAM AND PAP SMEAR
____
DATE OF G. EXAM_____________________DATE OF PAP SMEAR_________________

** CONTINUE PLEASE **

IN THE LAST 6 MONTHS, WHICH OF THE FOLLOWING SYMPTOMS HAVE YOU EXPERIENCED?

	NEVER	SOMETIMES	OFTEN
DIFFICULT TO STOP BLEEDING?	______	__________	______
EXCESSIVE APPETITE	______	__________	______
LOOSE STOOLS OR DIARRHEA	______	__________	______
DIGESTION PROBLEMS	______	__________	______
VOMITING	______	__________	______
BELCHING OR BURPING	______	__________	______
HEARTBURN	______	__________	______
FEELING OF FOOD RETENTION	______	__________	______
COUGH	______	__________	______
SHORTNESS OF BREATH	______	__________	______
DECREASED SENSE OF SMELL	______	__________	______
SKIN PROBLEMS	______	__________	______
FEELING OF CLAUSTROPHOBIA	______	__________	______
BRONCHITIS	______	__________	______
COLITIS OR DIVERTICULITIS	______	__________	______
CONSTIPATION	______	__________	______
HEMORRHOIDS	______	__________	______
RECENT USE OF ANTIBIOTICS	______	__________	______
LOW BACK PAIN	______	__________	______
SCIATICA	______	__________	______
KNEE PROBLEMS	______	__________	______
HEARING IMPAIRMENT	______	__________	______
RINGING IN EARS	______	__________	______
KIDNEY STONES	______	__________	______
DECREASED SEX DRIVE	______	__________	______
HAIR LOSS	______	__________	______
URINARY PROBLEMS	______	__________	______
INSOMNIA, DIFFICULTY SLEEPING	______	__________	______
HEART PALPITATIONS	______	__________	______
NIGHTMARES	______	__________	______
MENTALLY RESTLESS	______	__________	______
LAUGHING FOR NO APPARENT REASON	______	__________	______
ANGINA PAINS	______	__________	______
EYE PROBLEMS	______	__________	______
JAUNDICE (YELLOWISH EYES OR SKIN)	______	__________	______
HEPATITIS	______	__________	______
DIFFICULTY DIGESTING OILY FOODS	______	__________	______

** CONTINUE PLEASE **

GALL STONES	______	__________	______
LIGHT COLORED STOOLS	______	__________	______
SOFT OR BRITTLE NAILS	______	__________	______
EASILY ANGERED OR AGITATED	______	__________	______
SPASMS OR TWITCHING OF MUSCLES	______	__________	______
FATIGUE	______	__________	______
EDEMA	______	__________	______
BLOOD IN STOOLS	______	__________	______
EASILY BRUISED	______	__________	______
ASTHMA	______	__________	______
TENDENCY TO CATCH COLDS EASILY	______	__________	______
INTOLERANCE TO WEATHER CHANGES	______	__________	______
ALLERGIES	______	__________	______
HAYFEVER	______	__________	______
TENDENCY TO FAINT EASILY	______	__________	______
HIGH BLOOD PRESSURE	______	__________	______
HIGH CHOLESTEROL	______	__________	______
SUDDEN WEIGHT LOSS	______	__________	______

ANY RELATED COMMENTS THAT YOU WOULD LIKE TO SHARE WOULD BE APPRECIATED:
____
____
____
____

PATIENT’S SIGNATURE:
____

DATE: _________________________

** CONTINUE PLEASE **

**** IF YOU DO NOT HAVE PAIN, STOP HERE ****

1. HOW LONG HAVE YOU HAD THE PRESENT PAIN? ______________________________

2. HOW LONG HAVE YOU BEEN OFF WORK OR HOUSEWORK? ________________________

3. (CHECK APPROPRIATE BOX)

MY PAIN BEGINS:
( ) GRADUALLY
( ) SUDDENLY

( ) FROM INJURY

AND IS:
( ) OFF AND ON
( ) CONTINUOUS

IS WORSE WHEN I:
( ) COUGH OR SNEEZE
( ) SIT DOWN
( ) BEND FORWARD
( ) LAY DOWN
( ) WAKE UP
( ) WALK

( ) AFTER SURGERY

4. HAVE ANY TREATMENTS MADE YOUR PAIN BETTER?
____
____
____

5. HAVE ANY TREATMENTS MADE YOUR PAIN WORSE?
____
____
____