

Confidential Health Questionnaire

Welcome to my Office

I will do everything possible to restore your health. I offer a gentle, caring, holistic approach and can use a wide variety of modalities to reach the root of your health problems. I look forward to working with you to help you achieve optimum health." Health is not just the absence of disease...it is more...a state of well being and wellness.

Name _____
 Address _____
 City _____ St _____ Zip _____
 Home Phone _____
 Work Phone _____
 Date of Birth _____ Age _____
 Male Female Height _____ Weight _____
 Chief Complaint _____
 Previous Treatment You've Received:

 Occupation _____
 Employed By _____
 Social Security # _____
 Driver's License # _____
 e-Mail Address _____
 Referred By _____

Signature _____

I am fully responsible for all fees, services, herbs and supplements. I understand that failure to cancel a scheduled appointment within 24 hours will result in a cancellation charge for that visit.

Medications Yes No
 Medications/Herbs _____ Purpose _____

Habits Heavy Moderate Light
 Coffee.....
 Drugs.....
 Tea.....
 Water.....
 Tobacco
 Alcohol
 Soft Drinks.....
 Stress.....

Have you ever been Hospitalized? Yes No
 If yes, explain _____

Have you had Previous Acupuncture?
 Yes No
 Reason _____

How Long Has It Been Since You Had:
 Complete Physical Exam _____
 Heart Exam _____
 Blood Pressure Check _____
 What is your Cholesterol _____

I am interested in hearing more about:
 Acupuncture
 Chinese Herbal Medicine
 Hormone Saliva Test
 Nutritional Analysis
 Allergy/Sensitivity Test
 Hair Analysis
 Detox Programs
 NAET (Allergy Elimination Techniques)
 Hormone Saliva Test
 Other _____

Have You Had Any of The Following:

| | Yes | No |
|---------------------------|--------------------------|--------------------------|
| Alcoholism/Drug Addiction | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Appendicitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Goiter | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Herpes | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| IBS/Crohn's | <input type="checkbox"/> | <input type="checkbox"/> |
| Influenza | <input type="checkbox"/> | <input type="checkbox"/> |
| Measles | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Mumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal Infection | <input type="checkbox"/> | <input type="checkbox"/> |

Any Falls, Accidents, Injuries?
 Yes No
 If Yes, explain _____

Ever Been Unconscious?
 Yes No
 If Yes, explain _____

Surgery? Yes No
 If Yes, kind(s) and date(s) _____

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SYMPTOMS

General severe.... mild.... none

Allergy.....

Chills/Fever.....

Cold Hands or Feet.....

Convulsions/Epilepsy.....

Dizziness.....

Fainting.....

Fatigue.....

Fever.....

Headache.....

Loss of Sleep.....

Loss of Weight.....

Nervousness.....

Nerve Pain.....

Numbness/Tingling.....

Unclear Thinking.....

Muscle and Joint

Back Pain/Sciatica.....

Elbow/Shoulder.....

Knee/Foot.....

Hernia.....

Painful Tailbone.....

Spinal Curvature.....

Stiff Neck.....

Tremors.....

Swollen Joints.....

Cardio-Vascular

Hardening of Arteries.....

Blood Pressure.....

Pain Over Heart.....

Poor Circulation.....

Irregular Heart Beat.....

Stroke.....

Swelling of Ankles.....

Gastrointestinal severe.... mild.... none

Acid Reflux.....

Belching or Gas.....

Colitis.....

Colon Trouble.....

Constipation.....

Diarrhea.....

Difficult Digestion.....

Abdomen Distention.....

Excessive Hunger.....

Gall Bladder Trouble.....

Hemorrhoids (piles).....

Worms/Parasites.....

Liver Trouble.....

Nausea.....

Stomach Pain.....

Poor Appetite.....

Vomiting.....

E.E.N.T.

Asthma.....

Deafness.....

Dental Decay.....

Ear/Eye Trouble.....

Enlarged Glands.....

Enlarged Thyroid.....

Failing Vision.....

Far Sightedness.....

Frequent Colds.....

Hay Fever.....

Hoarseness.....

Gum Trouble.....

Nose Bleeds.....

Near Sightedness.....

Sinus Infection.....

Sore Throat.....

Respiratory severe mild ... none

Chronic Cough.....

Difficult Breathing.....

Respiratory severe mild none

Shortness of Breath.....

Spitting up Blood.....

Wheezing/Phlegm.....

Skin

Boils.....

Bruises.....

Dryness.....

Eczema / Psoriasis.....

Hives.....

Itching.....

Sensitive Skin.....

Varicose Veins.....

Genito/Urinary

Bed Wetting.....

Blood in Urine.....

Frequent Urination.....

Inability to Control Urine.....

Kidney Infection/Stones.....

Painful Urination.....

Prostate Trouble.....

Pus in Urine.....

Urinary Tract Infections.....

For Women Only/General

Ammenorrhea.....

Cramps or Backache.....

Excessive Flow.....

Fibroids.....

Hot Flashes.....

Irregular Cycle.....

Lumps in Breast.....

PMS /(Peri)Menopausal.....

Painful Menstruation.....

Vaginal Discharge.....

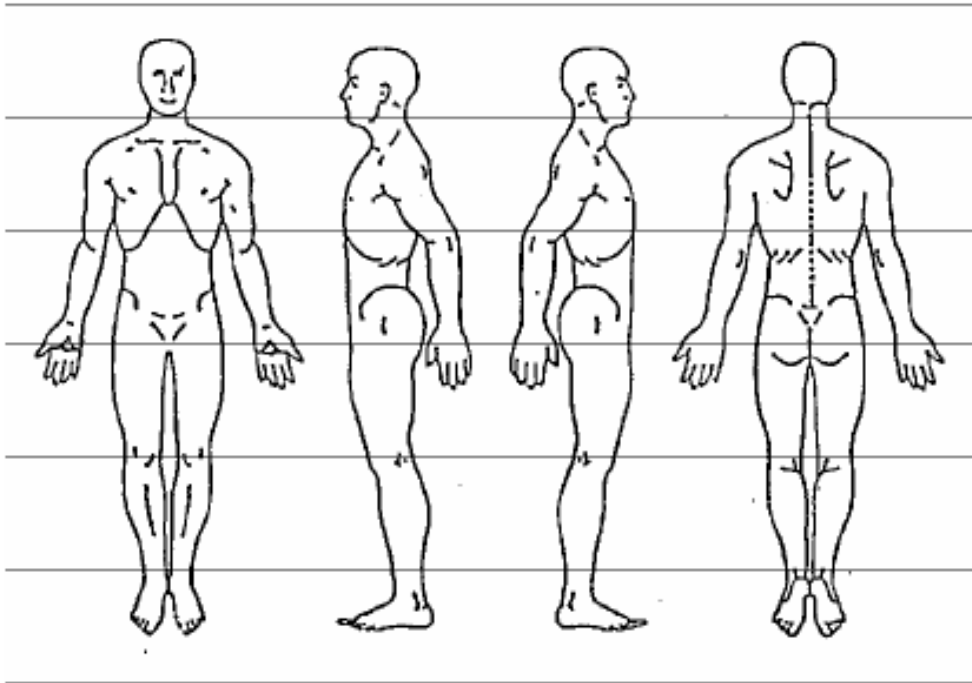
Last Period Date ____/____/____

Hysterectomy ____/____/____

Previous Miscarriage ... Yes No

Confidential Health Questionnaire

Please drag your cursor to create a box over the areas of pain/concern:



Sensations/pain: Sharp Burning Moves Tingling Dull
 Severe Shooting Distending Numbness

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____

What aggravates the pain? (weather, heat, cold, etc.)? _____

Pain Began: ____/____/____