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STEP ONE:

All new patients are requested to carefully read the included materials and fill out this Health History Questionnaire.

STEP TWO:

A one-on-one evaluation and history will be done to discuss your health concerns and to determine what may be the cause. If we can help you, we will go to Step #3.

STEP THREE:

An Oriental Medical examination—including classical pulse diagnosis and tongue diagnosis—will be given to determine the cause of your problem(s).

STEP FOUR:

You will go through a series of treatments—called a Report of Findings—during which we will educate you regarding the cause of your problem. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised on how our office procedures work.

STEP FIVE:

An estimate of the future care that is needed will continue until the personal maximum correction of your problem has been obtained.

STEP SIX:

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Today's Date____/____/___

Patient Name_____
FIRST MIDDLE INITIAL LAST

Address_____
STREET CITY/TOWN STATE ZIP CODE

Telephone: (Home)_____ (Cell)_____

(Work)_____ (Check off preferred contact #)

Email Address_____

Date of Birth ____/____/_____ Age_____ Weight_____

Social Security #_____ Marital status: S D M W

Occupation _____ Employer_____

Current Physician_____ Phone #_____

Insurance Co._____ State_____

Subscriber's relationship to patient_____ Subscribers Employer_____

How did you hear about us?—Please be specific

☐ A person:_____ ☐ Insurance company/website:_____

☐ Online:_____ ☐ Other:_____

Health Care Objectives

Most patients who come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). We will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you would like us to select the type of care appropriate for your condition

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HEALTH HISTORY QUESTIONNAIRE

Name:_____ **Date**_____/_____/_____

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional:_____

When did you first start experiencing these problems?_____

How do these conditions impair your daily activities?_____

_____

II Patient Medical History
(Please include dates)

- ☐ Anemia_____
- ☐ Cancer_____
- ☐ Chronic Fatigue Syndrome_
- ☐ Diabetes_____
- ☐ Epilepsy_____
- ☐ Fibromyalgia_____
- ☐ Heart Disease_____
- ☐ Hepatitis_____
- ☐ High Blood Pressure_____
- ☐ H.I.V._____
- ☐ Kidney Disease_____
- ☐ Mononucleosis_____
- ☐ Nervous Breakdown_____
- ☐ Seizures_____
- ☐ Stroke_____
- ☐ TB_____
- ☐ Thyroid Disease_____
- ☐ Venereal Disease_____

How was your childhood health?_____

_____

Surgeries (type and date):_____

_____

Significant Trauma (physical, emotional, chemical, etc.)_____

_____

Do you exercise regularly? ☐ Yes ☐ No Briefly describe_____

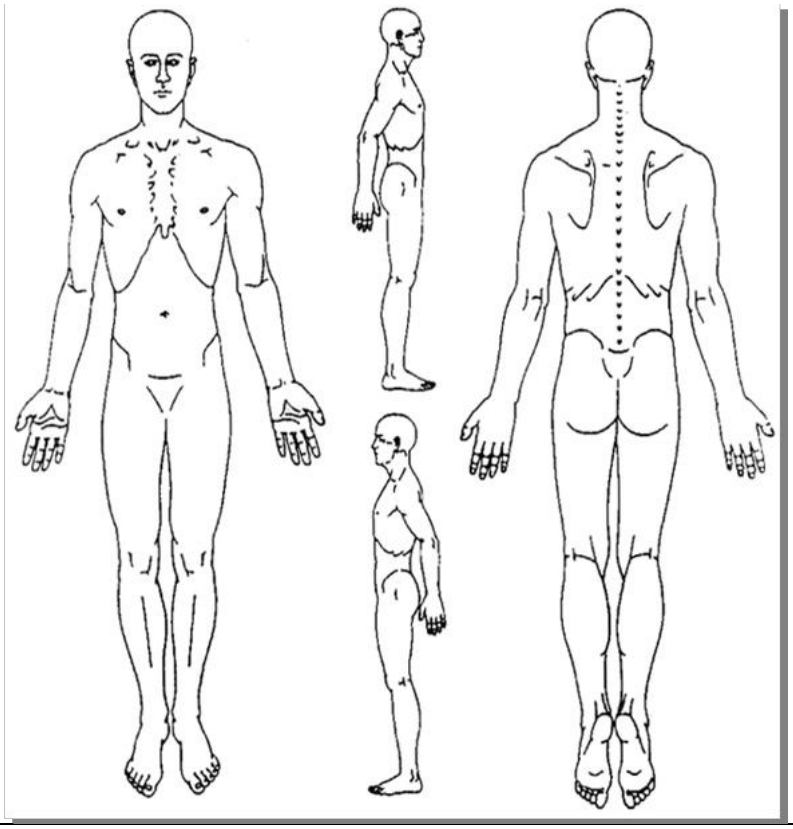
Allergies/Sensitivities (drugs, chemicals, foods)_____

Please list current medications, dose and start date:

1. 5.
2. 6.
3. 7.
4. 8.

III Patient Profile

Please circle particular areas of discomfort



Type of pain/discomfort:

❑Sharp ❑Burning ❑Aching

❑Cramping ❑Dull ❑Moving

❑Electrical ❑Numbness ❑Tingling

❑Throbbing ❑Other:_____

Degree of discomfort

On a 1-10 scale (10=worst), please indicate on the diagram the degree to which each area bothers you by writing a # next to each area that bothers you.

Do the following improve the pain?

❑Pressure ❑Cold ❑Heat

❑Exercise ❑Other_____

Do the following worsen the pain?

❑Pressure ❑Cold ❑Heat

❑ Weather ❑Other:_____

(*Office use*)	2	3	4	5	6	7	8	9
A /10								
B /10								
C /10								
D /10								
E /10								
Total								

Initial Visit:

For the following that currently pertain to you,

PLEASE CIRCLE:1 (MILD), 2 (MODERATE), 3 (SEVERE)

or 0 / leave blank if it does not apply to you

Or check-off the box, where available

(The boxes to the right of the #'s are for follow-up Re-Exams only)

Follow-up Re-exam ONLY

Write in the new #: 1 2 or 3 of the current symptom level. Leave blank if it no longer applies

Overall Temperature (Yin & Yang) *The following symptoms indicate an imbalance of Yin and Yang in your body. In Oriental Medicine, Yin is the cool, moist, nourishing aspect of the body. Yang is the hot, dry, invigorating aspect of the body.*		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6	Re-Exam 7
Cold hands	0 1 2 3							
Cold fingers	0 1 2 3							
Cold feet	0 1 2 3							
Cold toes	0 1 2 3							
Sweaty hands	0 1 2 3							
Sweaty feet	0 1 2 3							
Feel hot easily	0 1 2 3							
Feel cold easily	0 1 2 3							
Afternoon flushes	0 1 2 3							
Night sweats	0 1 2 3							
Heat in the hands, feet, chest	0 1 2 3							
Hot flashes any time of the day	01 2 3							
Thirsty	0 1 2 3							
Perspire easily	0 1 2 3							
Lack of perspiration	0 1 2 3							

Overall energy (Lung, Kidney function):		Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6	Re-Exam 7
Shortness of breath	0 1 2 3							
Difficulty keeping eyes open in the daytime	0 1 2 3							
General weakness	0 1 2 3							
Easily catch colds	0 1 2 3							
Low energy	0 1 2 3							
Feel worse after exercise	0 1 2 3							
Overall function of the blood (Liver, Spleen, Heart function)								
Dizziness	0 1 2 3							
See floaters/black spots	0 1 2 3							
Areas of numbness or tingling	0 1 2 3							

Heart function: *The following symptoms are indicators of heart malfunction. The heart governs the blood & blood vessels, manifests in the complexion, governs the emotions, affects speech and taste, and controls perspiration.*		Re-exam 1	Re-exam 2	Re-exam 3	Re-exam 4	Re-exam 5	Re-exam 6	Re-exam 7
Palpitations	0 1 2 3							
Anxiety	0 1 2 3							
Easily startled	0 1 2 3							
Sores on the tip of the tongue	0 1 2 3							
Restlessness	0 1 2 3							
Mental confusion	0 1 2 3							
Chest pain moving to shoulder	0 1 2 3							
Difficulty falling asleep	0 1 2 3							
Difficulty staying asleep	01 2 3							
Frequent dreams	0 1 2 3							
Wake un-refreshed	0 1 2 3							
Lung function: *The following symptoms are indicators of lung malfunction. The lungs govern breathing, oxygenate the blood, control the immune system, regulate water passages, control the skin and open into the nose, throat, and sinuses.*								
Nasal Discharge Color:	0 1 2 3							
Cough	0 1 2 3							
Nose Bleeds	0 1 2 3							
Sinus Congestion	0 1 2 3							
Dry mouth	0 1 2 3							
Dry throat	0 1 2 3							
Dry Nose	0 1 2 3							
Dry Skin	0 1 2 3							
Weak immune system	0 1 2 3							
Allergies: To what?	0 1 2 3							
Alternating fever and chills	0 1 2 3							
Sneezing	0 1 2 3							
Headaches:frontal/sinus	0 1 2 3							
Overall body aches	0 1 2 3							
Stiff neck	0 1 2 3							
Stiff shoulders	0 1 2 3							
Sore throat	0 1 2 3							
Difficulty breathing	0 1 2 3							
Smoke cigarettes❑ # per day:								
Sadness	0 1 2 3							
Melancholy	0 1 2 3							

Spleen function: *The following symptoms are indicators of spleen malfunction. The spleen assists in breaking food down into usable nutrients and transports those nutrients throughout the body, keeps the blood in the blood vessels, governs the muscles, manifests in the lips and holds the organs up in the body.*		Re-exam 1	Re-exam 2	Re-exam 3	Re-exam 4	Re-exam 5	Re-exam 6	Re-exam 7
Low appetite	0 1 2 3							
Abrupt weight gain	0 1 2 3							
Abrupt weight loss	0 1 2 3							
Abdominal bloating	0 1 2 3							
Abdominal gas	0 1 2 3							
Gurgling noise in the stomach	01 2 3							
Fatigue after eating	0 1 2 3							
Easily bruised	0 1 2 3							
Hemorrhoids	0 1 2 3							
Pensive	0 1 2 3							
Over-thinking	0 1 2 3							
Spleen, Stomach, Intestine function: *Bowel movements*								
Loose/unformed	0 1 2 3							
Frequent	0 1 2 3							
Constipated	0 1 2 3							
Straining	0 1 2 3							
Pain with bowel movement	0 1 2 3							
Incomplete feeling	0 1 2 3							
Diarrhea	0 1 2 3							
Blood in stools	0 1 2 3							
Mucous in stools	0 1 2 3							
Undigested food in stools	0 1 2 3							
Burning around the anus	01 2 3							
Dampness trapped in the body: *The following symptoms are indicators of "dampness," which simply refers to fluids that are not metabolized effectively and cause health problems in the body.*								
General sensation of body heaviness	0 1 2 3							
Mental sluggishness	0 1 2 3							
Mental heaviness	0 1 2 3							
Mental fogginess	0 1 2 3							
Struggle starting the day	0 1 2 3							
Swollen hands	0 1 2 3							
Swollen feet	0 1 2 3							
Swollen joints	0 1 2 3							
Chest congestion	0 1 2 3							
Snoring	0 1 2 3							
Feel worse in damp/rainy weather	0 1 2 3							

Stomach function: *The following symptoms are indicators of stomach malfunction. The stomach controls the breakdown of food and nutrients, descends energy and is the origin of the fluids.*	Re-exam 1	Re-exam 2	Re-exam 3	Re-exam 4	Re-exam 5	Re-exam 6	Re-exam 7
Burning after eating 0 1 2 3							
Large appetite 0 1 2 3							
Frequent hunger 0 1 2 3							
Bad breath 0 1 2 3							
Mouth (canker) sores 0 1 2 3							
Bleeding, swollen or painful gums 0 1 2 3							
Heartburn 0 1 2 3							
Acid regurgitation 0 1 2 3							
Ulcer (diagnosed) 0 1 2 3							
Belching 0 1 2 3							
Hiccoughs 01 2 3							
Stomach pain 0 1 2 3							
Vomiting 0 1 2 3							
Nausea 0 1 2 3							
Liver, Gall Bladder function: *The following symptoms are indicators of liver malfunction. The liver stores the blood, ensures the smooth flow of energy throughout the body, nourishes the tendons and ligaments, manifests in the nails and opens in the eyes. The gall bladder stores bile, which breaks down fats.*							
Alternating diarrhea and constipation 0 1 2 3							
Tight sensation in the chest 01 2 3							
Bitter taste in the mouth 01 2 3							
Anger easily 01 2 3							
Frustration 01 2 3							
Depression 01 2 3							
Irritability 01 2 3							
Unable to adapt to stress 01 2 3 (What causes the stress? .)							
Skin rashes 01 2 3							
Headaches 01 2 3							
Tingling sensation 01 2 3							
Numbness 01 2 3							
Muscle spasms 0 1 2 3							
Muscle twitching 01 2 3							
Muscle cramping 01 2 3							
Seizures 01 2 3							
Lump in the throat 01 2 3							
Neck tension 01 2 3							
Drink coffee ❑ Cups per day:							
Drink alcohol ❑ Drinks/day:							

	Re-exam 1	Re-exam 2	Re-exam 3	Re-exam 4	Re-exam 5	Re-exam 6	Re-exam 7
Neck Limited Range-of-Motion 01 2 3							
Shoulder tension 01 2 3							
Shoulder Limited Range-of-Motion 0 1 2 3							
Hip pain 0 1 2 3							
High-pitched ringing in the ears 0 1 2 3							
Gall stones (history or current) ❑							
Sexually transmitted disease ❑ (Which?)							
Eyes (Liver function):							
Itchy 01 2 3							
Bloodshot 01 2 3							
Hot 0 1 2 3							
Dry 01 2 3							
Watery 01 2 3							
Gritty 01 2 3							
Blurry vision 0 1 2 3							
Decreased night vision 0 1 2 3							
Kidney, Urinary Bladder function: *The following symptoms are indicators of kidney or urinary bladder malfunction. The kidney and adrenal system govern growth/development /reproduction, produce the bone marrow, nourish the brain, control the bones, govern water, open to the ears, manifest in the hair, and control the ureter/ spermatic duct and lower section of the large intestine. The urinary bladder stores and eliminates impure fluids from the body.*							
Sore knees 0 1 2 3							
Weak knees 0 1 2 3							
Cold sensation in the knees 01 2 3							
Low back pain 01 2 3							
Memory problems 0 1 2 3							
Excessive hair loss 01 2 3							
Low-pitched ringing in the ears 012 3							
Bladder infections 0 1 2 3							
Wake at night twice or more to urinate 0 1 2 3							
Lack of bladder control 0 1 2 3							
Fear 0 1 2 3							
Kidney stones ❑							
Frequent cavities ❑							
Easily broken bones ❑							

Urination:								
Urgent	01 2 3							
Frequent	0 1 2 3							
Dark yellow	0 1 2 3							
Reddish	01 2 3							
Cloudy	01 2 3							
Scanty	0 1 2 3							
Profuse	01 2 3							
Smelly	01 2 3							

Burning	01 2 3							
Painful	01 2 3							
Discharge	01 2 3							
Difficult to void	01 2 3							
Libido (Sex Drive):								
Normal ❑								
Strong ❑								
Weak ❑								

How would you rate your **general health** in these categories? **Great** ---------- **Bad** (0=Great, 5=Bad) **0 1 2 3 4 5** (circle one)	Re-exam 1	Re-exam 2	Re-exam 3	Re-exam 4	Re-exam 5	Re-exam 6	Re-exam 7
0 1 2 3 4 5 OVERALL HEALTH							
0 1 2 3 4 5 MENTAL CLARITY (without caffeine or other stimulants)							
0 1 2 3 4 5 SLEEP QUALITY							
0 1 2 3 4 5 MOBILITY (ease of movement)							
0 1 2 3 4 5 GENERAL ENERGY LEVELS (without caffeine or other stimulants)							

MEN ONLY:
Swollen testes ❑ Testicular pain ❑ Impotence ❑ Premature ejaculation ❑
Feeling of coldness or numbness in external genitalia ❑ Other ❑_____

WOMEN ONLY::
Date of last period:_____ Age of menopause (if applicable):_____
Age of first menstruation:_____ Is there any chance you are pregnant? Y ❑ N ❑
Average number of days of flow:_____ Number of children:_____
Average number of days of entire cycle:_____ Number of pregnancies:_____
Regular menstrual cycle? ❑Y ❑N Birth Control:_____

Do you experience: Menstrual pain? Y❑N❑ Avg # days:_____ Dull❑ Sharp❑ Pain at worst__/10 Where:_____
Menstrual clots? Y❑N❑ Large❑ Small❑ Color:_____

Do you experience any of the following premenstrual symptoms		Re-exam 1	Re-exam 2	Re-exam 3	Re-exam 4	Re-exam 5	Re-exam 6	Re-exam 7
Fatigue, Avg. # days:	0 1 2 3							
Menstrual pain	0 1 2 3							
Nausea	0 1 2 3							
Indigestion	0 1 2 3							
Constipation	0 1 2 3							
Diarrhea	0 1 2 3							
Vomiting	0 1 2 3							
Headaches	0 1 2 3							
Migraines	0 1 2 3							
Breast swelling	0 1 2 3							
Breast tenderness	0 1 2 3							
Anxiety	0 1 2 3							
Irritability	0 1 2 3							
Depression	0 1 2 3							
Other emotion:	0 1 2 3							
Difficulty sleeping	0 1 2 3							
Water retention	0 1 2 3							

Do you experience:								
Vaginal discharge, Color:	01 2 3							
Yeast infections	01 2 3							
Urinary tract infections	01 2 3							
Bleeding or spotting between periods	01 2 3							
Pain between periods	01 2 3							
Menstrual clots	01 2 3							
Irregular cycle	01 2 3							
Heavy flow	01 2 3							
Light flow	01 2 3							
Menstrual flow starts/stops	01 2 3							
Other:	01 2 3							
Other:	01 2 3							

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____