Acupuncture Ecology

Please complete this questionnaire as thoroughly as possible. Indicate areas of confusion with a question mark.

PATIENT INFORMATION

Personal Information

NAME: LAST	FIRST	MIDDLE	DATE:
ADDRESS			
CITY		STATE	ZIP
PHONE: HOME ( )	CELL ( )	FAX ( )	
EMAIL			
Which form of contact do you prefer? ❒ Home ❒ Cell (Call / Text) ❒ Work ❒ Email			
DATE OF BIRTH	AGE	HEIGHT	WEIGHT
SEX MARITAL STATUS ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other _____			
OCCUPATION			
CITY		STATE	
BUSINESS PHONE ( )			
EMERGENCY CONTACT	PHONE ( )	RELATIONSHIP	

When and where did you last receive health care?

PHYSICIAN/PROVIDER	PHONE ( )
ADDRESS	
DATE OF VISIT	
REASON FOR VISIT	

Other Information

How did you hear of this office?
Have you ever before tried acupuncture, herbal medicine, or qigong?

CHIEF COMPLAINT

What are the main health problems for which you are seeking treatment? A brief list will suffice. List Western medical diagnosis, if applicable.

Please rate the extent to which your current complaint affects your daily life (1 = minor; 10 = major)

1 2 3 4 5 6 7 8 9 10

What other forms of treatment have you sought?

Are there others in your family with the same condition? ❒ Yes ❒ No
If yes, please explain.

MEDICAL HISTORY

Please check each box that applies.

	Allergies		Endocrine Disorder
	Blood Disorder/Anemia		Stroke or Neurological Disorder
	High Blood Pressure		Infectious Disease
	Heart Disease		Tuberculosis
	Rheumatic Fever		Hepatitis
	Diabetes		Sexually Transmitted Disease
	Cancer or Tumors		Mental or Emotional Illness
	Seizures		Parasites
	Kidney or Bladder Disorder		Drug Abuse
	Stomach or Intestinal Disorder		Toxin exposure (chemical, radiation, etc.)

Other medical conditions (please describe)

List all known allergies (food, drug, chemical, environmental, etc.)

Vaccination history: Any reactions that you remember? Any unusual vaccinations?

List major illnesses, traumas, accidents, and surgeries.

DATE	OPERATION OR ILLNESS	HOSPITAL/LOCATION
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Please list any medications, herbs, vitamins, home remedies, etc. you are currently taking.

❒ Aspirin
❒ Ibuprofen
❒ Acetaminophen (Tylenol)
❒ Antacids
❒ Contraceptives (oral)
❒ Blood pressure medicine_____
❒ Blood thinning medicine_____
❒ Diet pills_____
❒ Other (please describe)

❒ Sleeping pills _____
❒ Laxatives_____
❒ Cold/flu medication_____
❒ Sedatives_____
❒ Allergy medicine_____
❒ Insulin/diabetes medicine_____
❒ Vitamins/herbs_____

LIFESTYLE

Please check any habits that apply, either <u>now</u> or <u>in the past</u>.

Coffee ❒ Yes ❒ No	Cups per day/week	Age started	Age quit	
Tea/Caffeinated Beverages ❒ Yes ❒ No	Use per day/week	Age started	Age quit	
Soda ❒ Yes ❒ No	Use per day/week	Age started	Age quit	
Tobacco ❒ Yes ❒ No	Use per day/week	Age started	Age quit	
Alcohol ❒ Yes ❒ No	Use per day/week	Age started	Age quit	
Marijuana ❒ Yes ❒ No	Use per day/week	Age started	Age quit	
Other_____	Use per day/week	Age started	Age quit	

Typical diet
Breakfast: Lunch: Dinner: Snacks:
Please describe any dietary restrictions you have, for any reason (medical, religious, etc.)
Please describe any exercise you do.

MALE ONLY

Please check all that apply.

- ❒ Prostate concerns
  - PSA level, if applicable_____
- ❒ Painful, excessive, or decreasing urination
- ❒ Discolored urine
- ❒ Painful/itching genitalia
- ❒ Genital lesions or discharge
- ❒ Genital deformity or lumps
- ❒ Impotence or other sexual dysfunction
- ❒ Significant change in sex drive
- ❒ Other (please describe)

Any other male concern not addressed

FEMALE ONLY

Age of 1st Period

Age at Menopause (if applicable)

Total # Pregnancies

Live Births

#Miscarriages/Abortions

Please check all that apply.

- ❒ Menstrual irregularity
- ❒ Menstrual cramps
- ❒ Painful, excessive, or decreasing urination
- ❒ Discolored urine
- ❒ Breast lumps
- ❒ Breast pain or tenderness
- ❒ Breast fluid discharge
- ❒ Menopausal syndrome
- ❒ Painful/itching genitalia
- ❒ Genital lesions or discharge
- ❒ Genital deformity
- ❒ Sexual dysfunction
- ❒ Significant change in sex drive
- ❒ Fibroids or cysts
- ❒ Other (please describe)

Date of last Pap

Abnormal? (Y/N)

Date of last mammogram

Date of last menstrual period

Birth control used?
❒ Yes ❒ No

If yes, what type?

Do you have any reason to believe you may currently be pregnant? ❒ Yes ❒ No
If so, how far along are you?

Any other female concern not addressed