HEALTH HISTORY QUESTIONNAIRE

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential*. If you have questions, don't hesitate to ask. Please feel free to discuss any other health concerns you may have. Thank you.

Date

Name	Home phone: Cell/Text:		Work phone: Email:	
Street	City		State/Zip	
Date of Birth	☐ Male ☐ Female	Age	Height	Weight
Occupation	Primary Care Physician		Referred By	
Emergency Contact - Name (First & Last)	Emergency Contact - Phone		Relation to you	

Have you been treated by acupuncture or Oriental medicine before? ☐Yes ☐No
Main problem(s) you would help with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, such as work, sleep, and sex?
Have you been given a diagnosis for this problem? If so, what?
What other kinds of treatment have you tried?

YOUR PAST MEDICAL HISTORY (please include dates)
Significant Illnesses *(please circle all applicable)*

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

Thyroid Disease Seizures Venereal Disease Other (please specify):

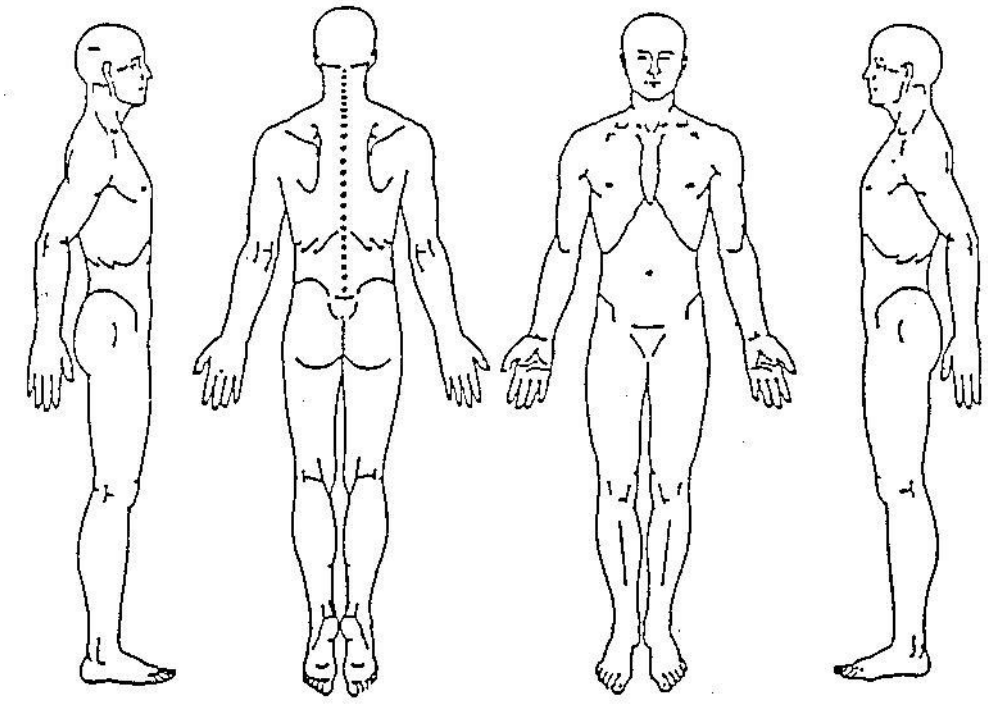
Surgeries
Significant trauma (auto accidents, falls, etc.)
Allergies (drugs, chemicals, foods)

<u>FAMILY</u> Medical History*(please circle all applicable)*

Asthma	Allergies	Diabetes	Cancer	Heart Disease	High Blood Pressure
Stroke	Seizures	Thyroid	Other (please specify):		

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)		
Occupational stress (chemical, physical, psychological, etc.)		
Do you have a regular exercise program? If yes, please describe.		
Please describe your average daily diet:		
Morning:	Afternoon:	Evening:
Do you smoke? If yes, how much?		
How much caffeinated coffee, tea, or cola do you drink per week?		
How much water do you drink per day?	How much alcohol do you drink?	
Please describe any use of drugs for non-medical purposes.		

Please indicate any painful or distressed areas by circling the area.



Name: _____ Date: _____

Please check if you have had (IN THE LAST THREE MONTHS):

General

- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Chills
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Strong thirst (hot or cold drinks)
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Sudden energy drop (time of day?)

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems?
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Any other head or neck problems?
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches (where, when?)

Cardiovascular

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Any other heart or blood vessel problems?
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of feet
- ☐ Swelling of hands
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Peripheral Arterial Sclerosis
- ☐ Varicose veins

Respiratory

- ☐ Cough
- ☐ Coughing blood
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Production of phlegm. What color?
- ☐ Any other lung/breathing problems?
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ Wheezing while breathing
- ☐ Difficulty in breathing when lying down
- ☐ Shortness of breath
- ☐ Pain with a deep breath

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Gas
- ☐ Belching
- ☐ Any other problems with your stomach or intestines?
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Black stools
- ☐ Chronic laxative use
- ☐ Abdominal pain or cramps
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Bad breath
- ☐ Bleeding gums

Urinary

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Pain upon urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Kidney stones
- ☐ Any particular color to your urine:
- ☐ Do you wake up to urinate? How often?
- ☐ Any other problems with your or urinary system?

Male Reproductive

- ☐ Impotence
- ☐ Prostatitis
- ☐ Prostate Cancer
- ☐ Premature Ejaculation
- ☐ Low sperm count
- ☐ Low motility
- ☐ Testicular pain/injury
- ☐ Testicular Cancer
- ☐ Sores on genitals
- ☐ STDs
- ☐ Any other reproductive problems?

Female Reproductive

Are you pregnant? Yes No

Is it possible that you are pregnant? Yes No

- ☐ Age of first menses: _____
- ☐ Duration of menses: ____
- ☐ Time between menses: ____
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Unusual character (heavy/light)
- ☐ Clots
- ☐ Pregnancies #: _____
- ☐ Live births #: _____
- ☐ Premature births #:_____
- ☐ Miscarriages #: _____
- ☐ Abortions #: _____
- ☐ Infertility
- ☐ Western Fertility Treatment
- ☐ Menopause Age: _____
- ☐ Last PAP
- ☐ Vaginal discharge
- ☐ Breast lumps
- ☐ Sores on genitals
- ☐ STDs
- ☐
- ☐ Changes in body/psyche prior to menstruation
- ☐ Do you practice birth control? What type and for how long?
- ☐ Any other reproductive problems?

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Any other muscle, joint or bone problems?

Neurological

- ☐ Seizures
- ☐ Stroke
- ☐ Concussion
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Lack of coordination
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Tremors (where?)
- ☐ Any other neurological problems?

Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ Fearful
- ☐ Easily angered
- ☐ Easily susceptible to stress
- ☐ Easily over worried
- ☐ Sadness
- ☐ Overly joyful

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

- ☐ Any other neurological or psychological problems?

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Patient Name: _____

Address: _____

City/State/Zip: _____

Please check best method of reaching you

Telephone: ☐ Daytime _____

☐ Evening _____

☐ Cell/Text _____

☐ Email _____

POLICIES & INFORMED CONSENT

Payment Policy:

- Payment for appointment is required at the time of your visit. Time of service discounts available for follow up appointments. Preferred payment is cash or check. Credit card payment available for your convenience. Returned checks will incur a $35.00 fee, due and payable immediately.
- A limited number of Insurance Companies now cover Acupuncture Services. Please note: you are responsible for all charges not honored by your insurance carrier.

Cancellation Policy:

- Please be on time for your scheduled appointment.
- If you find it necessary to change or cancel your appointment, please try and give as much advanced notice as possible. A minimum of 24 hours notice to cancel an appointment is required otherwise you will be responsible for the full cost of the visit. Emergencies will be taken into consideration. More importantly, keeping regular appointments will produce a better therapeutic result.

Informed Consent:

I hereby authorize Sharon J. Levy, Licensed Acupuncturist to administer acupuncture therapy relevant to my diagnosis and treatment, including but not limited to the following:

- Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations. It is possible that the skin may bruise after the needle is removed. This is not serious and does not occur very often.
- Heat treatment using Artemesia Vulgaris herb (moxibustion, "moxa") or a therapeutic heat lamp. Indirect moxibustion treatments involve putting moxa on the head of the needle, holding a moxa pole near the skin or on top of a barrier such as salt or a slice of ginger. Direct moxa involves thread or cone size moxa placed directly on the skin. With any type of heat, there is always a risk of burn.
- Cupping may be used to promote circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area treated lasting 1-5 days.
- Tui Na (Chinese Therapeutic Massage) with herbal oils, poultice and liniments.
- Gwa Sha, a massage technique that leaves redness on the skin that can last 1-5 days. Slight bruising and tenderness may persist after the treatment.
- Electrical stimulation of the needles may be used which produces a vibration or tapping sensation or ion pumping cords may be attached to the needles.
- Bloodletting, alone or in conjunction with cupping may be used to improve circulation in specific meridians. Lancets are inserted into the skin and a small amount of blood is expressed from the puncture.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment and have been informed of the risks and possible consequences involved with this treatment. I also understand that there is always the possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. Please know that you are welcome to discuss any questions or concerns you may have at any point in our work together.

Signature of patient: _____

Printed name of patient: _____

Date: _____