Center for Acupuncture Oriental Medicine Inc.
Health Questionnaire

Please complete this questionnaire carefully. All information will be held in absolute confidence.

Name _____ Date _____

Address _____ Date of Birth _____/_____/_____ Age _____

City, State, Zip: _____ (P) Cell: _____

Email: _____ (P) Home: _____

Employer _____ Height _____ Weight _____

Occupation _____ Marital Status _____

Emergency contact _____ Emergency phone _____

Referred by: _____

Main Problem(s)_____

_____

Does this problem interfere with daily activities? Please explain. _____

_____

Have you been given a diagnosis for this problem?_____

_____

Personal History: (check all that apply, note history & treatment)

( ) Cancer	( ) Diabetes	( ) Hepatitis
( ) Heart Disease	( ) Sexually Transmitted Disease	( ) High Blood Pressure
( ) Thyroid Disease	( ) Seizures	( ) Other

Family Medical History (Please identify the family member's relation to you)

( ) Cancer	( ) Diabetes	( ) Allergies
( ) Heart Disease	( ) Asthma	( ) High Blood Pressure
( ) Stroke	( ) Seizures	( ) Other

Surgeries: (Please include date) _____

_____

_____

Significant Trauma: (Describe accidents, falls…with dates, treatment, & results) _____

_____

_____

_____

Medicines taken within the last two months (including OTC vitamins, drugs, herbs…) _____

_____

_____

Allergies: (Causes, symptoms, discomforts) _____

_____

How much coffee, tea, or cola do you drink a day? _____ How many cigarettes do you smoke a day? _____

How much alcohol do you drink during a typical week? _____

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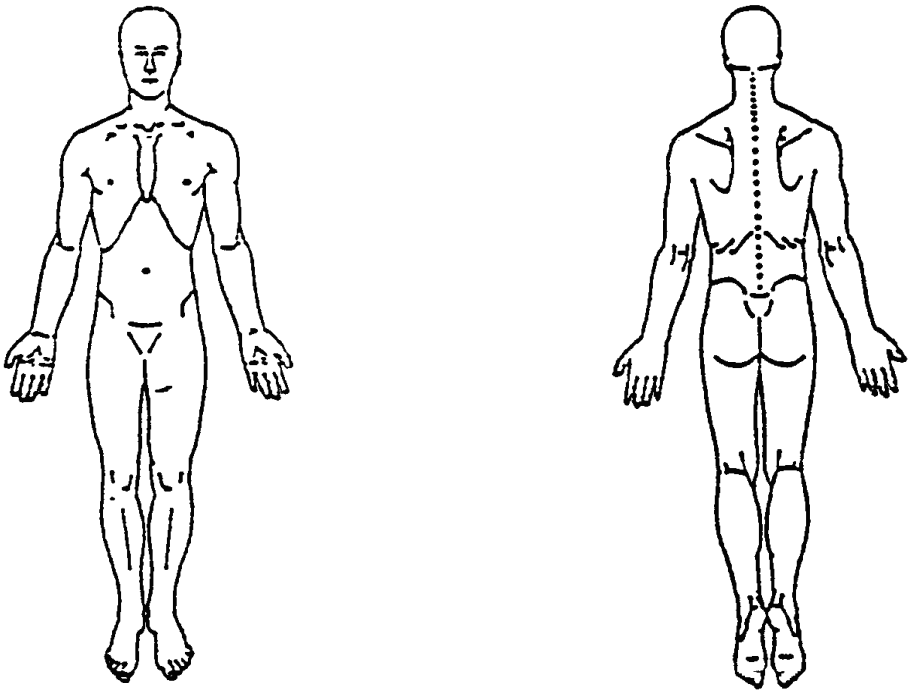
Indicate Painful or Distressed Areas. Explain as fully as possible.



Please explain if you have had any of the following within the last 3 months:

GENERAL:

( ) Poor Appetite
( ) Changes in Appetite
( ) Weight Loss
( ) Weight Gain
( ) Peculiar Tastes or Smells
( ) Cravings (circle all that apply)
sugar salt sour spicy
( ) Strong Thirst
( ) Fevers
( ) Chills
( ) Sweating Easily
( ) Night Sweats
( ) Bleed or Bruise easily
( ) Tremors
( ) Fatigue
( ) Poor Sleep / Trouble Sleeping
( ) Poor Balance
( ) Localized Weakness
( ) Sudden Energy Drop
Time of Day _____

SKIN & HAIR:

( ) Rashes
( ) Itches
( ) Dandruff
( ) Change in hair or skin texture
( ) Ulcerations
( ) Eczema
( ) Hair loss
Other _____
( ) Hives
( ) Pimples
( ) Recent Moles

CARDIOVASCULAR:

( ) High Blood Pressure
( ) Irregular heartbeat
( ) Cold Hands or Feet
( ) Blood Clots
( ) Low Blood Pressure
( ) Dizziness
( ) Swelling of Hands
( ) Phlebitis
( ) Chest Pain
( ) Fainting
( ) Swelling in Feet
( ) Difficulty in Breathing
Other Heart or Circulatory Problems _____

RESPIRATORY:

( ) Cough
( ) Bronchitis
( ) Coughing Up Blood
( ) Pneumonia
( ) Asthma
( ) Pain with Deep Breaths
( )Difficulty Breathing When Lying Down
( ) Production of Phlegm - Color? _____
Other Lung Problems _____

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HEAD, EYES, EARS, NOSE & THROAT:

( ) Recurrent Sore Throats ( ) Ear Aches ( ) Poor Vision
( ) Sores on Lips or Tongue ( ) Poor Hearing ( ) Cataracts
( ) Sinus Problems ( ) Teeth Problems ( ) Ringing in Ears
( ) Nose Bleeds ( ) Grinding Teeth ( ) Blurry Vision
( ) Facial Pain ( ) Clicking Jaw ( ) Eye Strain
( ) Concussion(s) ( ) Night Blindness ( ) Eye Pain
( ) Dizziness ( ) Glasses ( ) Spots in Front of Eyes
( ) Migraines ( ) Color Blindness

Headaches - where & when _____

Other head or neck problems _____

GASTROINTESTINAL:

( ) Nausea ( ) Vomiting ( ) Diarrhea
( ) Constipation ( ) Gas ( ) Belching
( ) Black Stools ( ) Blood in Stools ( ) Indigestion
( ) Bad Breath ( ) Rectal Pain ( ) Hemorrhoids
( ) Abdominal Pain or Cramps Other Stomach or Intestinal Problems _____

GENITO-URINARY:

( ) Pain on Urination ( ) Frequent Urination ( ) Blood in urine
( ) Urgent Urination ( ) Unable to Hold Urine ( ) Sores on Genitals
( ) Decrease in Urine Flow ( ) Kidney Stones ( ) Impotence
( ) Waking at night to Void - How Often _____ Color of Urine _____

Other Problems with Genitalia or Urinary System _____

REPRODUCTIVE & GYNECOLOGIC:

Pregnancies _____ Date of Last menses _____ ( ) Irregular Periods
Births _____ Length of Menses _____ ( ) No Periods
Miscarriages _____ Days Between Menses _____ ( ) Breast Lumps or Pain
Abortions _____ Flow: ( ) Heavy ( ) Light ( ) Chronic Yeast Infections
Last PAP _____ Clots: ( ) Dark ( ) Red ( ) Menopause - Age _____

Birth Control Type & Length of Use _____

Pain with Cycle: ( ) Beginning ( ) Ending ( ) Ovulation PMS: ( ) Psyche ( ) Body

Vaginal Discharge/Leukorrhea - please describe _____

MUSCULOSKELETAL:

( ) Neck pain ( ) Muscle Pain ( ) Knee Pain
( ) Back Pain ( ) Muscle Weakness ( ) Foot/Ankle Pain
( ) Hand/Wrist Pain ( ) Shoulder Pain ( ) Hip Pain

Other Joint or Bone Problems _____

NEUROPSYCHOLOGICAL:

( ) Seizures ( ) Dizziness ( ) Loss of Balance
( ) Areas of Numbness ( ) Lack of Coordination ( ) Poor memory
( ) Concussion ( ) Depression ( ) Anxiety
( ) Bad Temper ( ) Low Tolerance for Stress

Have you been treated for emotional problems? _____ Have you considered or attempted suicide?_____