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Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All your answers will be held absolutely confidential. If you have questions, please ask. We will also discuss these questions on the first visit. Thank you for being here!

Name: _____ Date: ____/____/_____

How did you Hear about us: _____

Telephone: Home: _____Work: _____ Cell: _____

Mailing Address: _____

Email address: _____

Height_____ Weight_____ Age_____ Date of Birth: _____ Place of Birth: _____

Occupation (Current) _____(Past) _____

Single / Married / Partnered / Separated / Divorced / Widowed

Emergency Contact: _____ Relationship to you: _____ Contact #_____

Primary Care Physician: _____

How would you like to be reminded of your next appointment? phone call / email / no reminder necessary

Have you ever used Chinese medicine for your health care? _____
For what reason? _____

Prioritize your most important health concerns today?

Concern	Onset	Frequency	Severity
Ex: Headache	June 1978	4 times/wk	mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Western Medical Diagnosis (if you have one)_____

With whom do you live?

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Children who don't live with you

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

What do you hope for and what are your expectations from this session today?

_____
_____
_____

On a long term basis?

_____
_____
_____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____
_____

Please list three things you would like to change about your health and well-being.

_____
_____
_____

Please list approximate dates and briefly describe any accidents, hospitalizations, surgeries, or major illnesses you have had.

_____
_____
_____
_____
_____

Please indicate areas of concern (pain, tension, numbness, tingling, swelling, etc.):

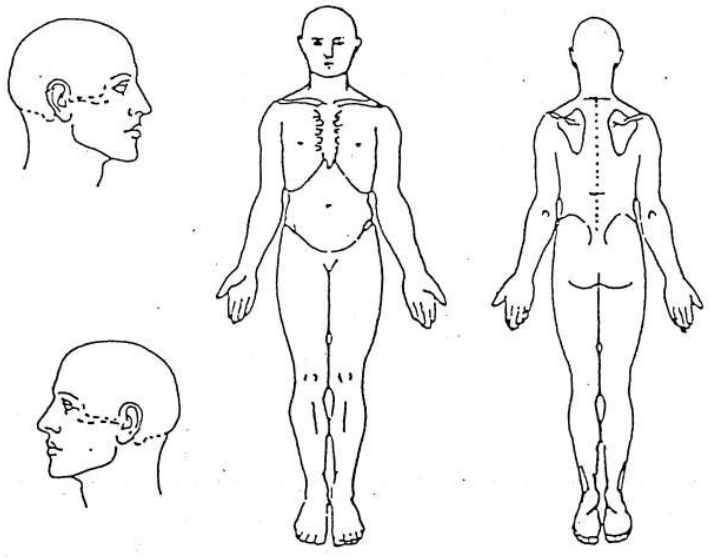
How long have you had this pain?_____
Describe the onset of your pain:_____

On a scale of 1-10 (10 worst), how strong is your pain?_____

What does your pain feel like?

_____
[ ] Dull [ ] Sharp [ ] Stabbing [ ] Sore [ ] Achy [ ] Cramping
[ ] Electrical [ ] Burning [ ] Constant [ ] Comes and goes
[ ] Fixed [ ] Moves around [ ] Other:

Does the pain radiate? Yes / No
If yes, where?_____
What helps the pain?_____
[ ] Ice [ ] Heat [ ] Rest [ ] Movement [ ] Pressure [ ] Moisture
[ ] Massage [ ] Nothing[ ] Other:



What aggravates the pain?_____
[ ] Ice [ ] Heat [ ] Rest [ ] Movement [ ] Pressure [ ] Moisture [ ] Massage [ ] Nothing [ ] Other:

What other treatments have you tried for this pain?_____

Medications, Herbs, & Supplements

Please list all medications (prescription and over-the-counter) and supplements that you are taking or have taken in the past for longer than 3 months. Please also note the reason for which each is taken.

Dosage **Reason** **How long**

_____
_____
_____
_____
_____

Diet and Lifestyle

Please list when and what you ate yesterday:

Breakfast_____ time: _____
Lunch_____ time: _____
Dinner_____ time: _____
Snacks_____ time: _____

Alcohol _____drinks per day/week Tobacco _____ per day/week Caffeine _____ per day/week

Are you recovering from any addictions? Please be specific. _____If yes, how long have you been clean? _____

Exercise (type(s)) _____ _____# times per week
TV/Video/Computer_____hours per day Do you use recreational drugs? If yes, what type?_____

How many hours per night do you sleep on average? _____ Do you wake rested? _____

How would you describe the quality of your sleep? _____

Have you experienced any major traumas? Y / N Explain: _____

Medical History

Please circle any symptoms or conditions you are experiencing either currently or have experienced in the past. Please indicate when each symptom or condition first appeared and for how long it lasted, if known.

Eyes

_____Blurred vision
_____Dryness
_____Redness, itchiness, or pain
_____Excessive tearing
_____Poor night vision
_____Spots or floaters
_____Double vision
_____Glaucoma
_____Cataracts
_____Other (describe)

Ears

_____Hearing loss
_____Ringing
_____Earache
_____Discharge or fullness
_____Other (describe)

Head and Neck

_____Dizziness or fainting
_____Vertigo
_____Headache/migraines
_____Swellings
_____Tension/stiffness
_____Other (describe)

Nose, Throat, and Mouth

_____Nasal congestion
_____Phlegm or discharge
_____Allergies
_____Sinus infection
_____Postnasal drip
_____Frequent cold/flu
_____Nosebleed
_____Dry nose
_____Dry mouth
_____Sores or swellings
_____Dental/gum problems
_____Jaw tension/tightness
_____Teeth grinding
_____Facial pain
_____Dry or sore throat
_____Strong thirst
_____Difficulty swallowing
_____Loss of voice
_____Other (describe)

Skin

_____Rashes or hives
_____Acne
_____Eczema/psoriasis
_____Itching or redness
_____Dry or oily skin
_____Abnormal sweating
_____Easy bruising
_____Lumps or swellings
_____Varicose veins
_____Other (describe)

Chest

_____Difficulty breathing
_____Frequent sighing
_____Chronic cough
_____Cough up mucous/blood
_____Tight or stuffy chest
_____Pneumonia or bronchitis
_____Palpitations
_____Rapid/irregular heartbeat
_____Chest pain
_____High or low blood pressure
_____Heart murmur
_____Heart disease
_____Other (describe)

Body and Limbs

_____Heaviness or stiffness
_____Limited range of motion
_____Numbness or tingling
_____Paralysis
_____Seizures or tremors

Sleep

_____Difficulty staying asleep
_____Disturbing dreams
_____Waking due to pain
_____Night sweats
_____Fatigue or energy drops
_____Restlessness or hyper
_____Waking to urinate
_____Other (describe)

Urinary

_____Urinary/kidney infection
_____Burning/hot urination
_____Cloudy urine
_____Strong odor
_____Blood in urine
_____Disrupted flow
_____Incomplete emptying
_____Frequent or urgent
_____Difficult urination
_____Incontinence
_____Other (describe)

Gastrointestinal

_____Low or excessive appetite
_____Bloating/flatulence
_____Abdominal heaviness
_____Nausea or vomiting
_____Belching or hiccupping
_____Heartburn or reflux
_____Sluggish digestion
_____Abdominal pain
_____Change in weight
_____Altered taste
_____Bad taste in mouth
_____Bad breath
_____Diarrhea/loose stools
_____Constipation
_____Difficult bowel movements
_____Laxative dependence
_____Blood in stool
_____Other (describe)

Urogenital (male and female)

_____Low or high libido
_____Pain or itching of genitals
_____Genital discharge or lesions
_____STD/STI
_____Other (describe)

Male

_____Impotence
_____Premature ejaculation
_____Nocturnal emissions
_____Lumps in testicles
_____Hernia
_____Enlarged prostate
_____Other (describe)

Female

(see attached form)

Hot and Cold

_____Feel hot or cold
_____Cold hands or feet
_____Desire hot or cold

Mental/Emotional

_____Poor memory
_____Foggy headedness
_____Difficulty focusing
_____Depression
_____Mood swings
_____Irritable/frustration/anger
_____Difficulty relaxing
_____Loneliness
_____Sensitivity
_____Shyness
_____Frequent crying
_____Worry
_____Anxiety
_____Compulsive behaviors
_____Suicidal thoughts
_____Eating disorder

FAMILY HEALTH HISTORY

	Age	Important Diseases/Illnesses	Deceased Y/N
Father			
Mother			
Children			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Do you have any info about your birth? _____
_____

Your mother's pregnancy?_____

Is there anything else you would like me to know? _____
_____
_____
_____

Thank you for taking the time to complete this form. We look forward to working with you!