Heart Body Mind Acupuncture
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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask. Thank you.

PERSONAL INFORMATION

Last Name _____ First Name _____ Gender _____
Date of Birth (MM/DD/YY) _____ Height _____ Weight _____ Home Address_____
City _____ State _____ Zip _____
Phone Number _____ Email _____
Emergency Contact Name:_____Phone(_____)_____
Marital Status _____ Number of children _____
Occupation: _____

Have you received acupuncture therapy before?
If yes, when _____

MEDICAL HISTORY

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) has:
_____
_____
_____

Please list the Medications you are taking, including supplements, vitamins and herbs.

Medicine	Dosage	Reason	How long	Prescribed by

Check the boxes if any of the following statements are true:
□ I have known allergies
□ I have a pacemaker
□ I am taking Coumadin/warfarin
□ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies or food/environmental sensitivities that you have.

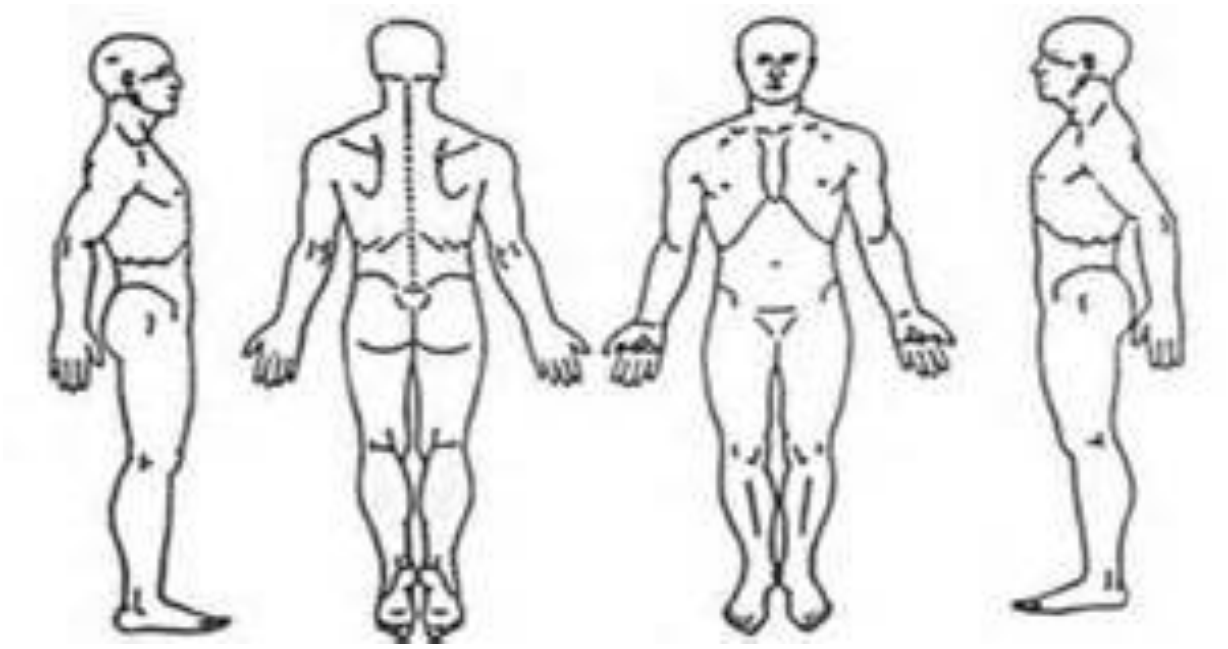
List any accidents, surgeries, or hospitalizations (include date).

Lab results (please provide us with a copy).

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor		Comment
Significant Other						
Family						
Diet						
Sex						
Self						
Work						
Exercise						

MARK AREAS OF CONCERN:



SURVEY OF SYMPTOMS

Please indicate which of the following conditions or symptoms you have experienced within the last 6 months.

SKIN AND HAIR

_____ Rashes	_____ Eczema	_____Ulcerations
_____ Acne	_____Itching	_____ Hair Loss
_____Dandruff	_____ New Moles	_____Pigment change

Other skin or hair conditions:

HEAD, EYES, EARS, NOSE, MOUTH AND THROAT

_____ Dizziness	_____ Migraine	_____Headache(Located:_____)
_____ Concussion	_____ Facial pain	_____ Cataract
_____ Poor vision	_____ Colorblindness	_____ Astigmatism
_____ Eye Pain	_____ Spots in eyes	_____ Night blindness
_____ Earache	_____ Ringing in ear	_____ Poor hearing
_____ Inability to smell	_____ Nosebleeds	_____ Sinus problems
_____ Runny nose	_____ Sore throat	_____ Teeth grinding
_____ Dental problems	_____ Jaw clicking	_____ Mouth/lip sores

Other head, eyes, nose, mouth and throat conditions:

CARDIOVASCULAR

_____ Chest Pain _____ Low BP _____ High BP
_____ Irregular heartbeat _____ Fainting _____ Cold hands and feet
_____ Swelling of hands _____ Swelling of feet _____ Blood clots
_____ Bleeding or bruising _____ Anemia _____ Genetic blood disorder

Other cardiovascular conditions:

RESPIRATORY

_____ Difficulty breathing _____ Cough _____Phlegm(Color___)
_____ Asthma _____ Pain on inhalation _____ Bronchitis
_____ Pneumonia _____ Wheezing

Other respiratory conditions:

DIGESTIVE

_____ Poor appetite _____ Weight gain _____ Weight loss
_____ Cravings _____ Strong thirst _____ Nausea
_____ Vomiting _____ Diarrhea _____ Constipation
_____ Gas / Bloating _____ Belching _____ Black stools
_____ Blood in stools _____ Indigestion _____ Bad breath
_____ Hemorrhoids _____ Rectal pain _____ Abdominal pain
_____ Gallstones

Other digestive or gastrointestinal conditions:

UROGENITAL

_____ Pain on urination _____ Urgency to urinate _____ Difficulty urinating
_____ Frequent urination _____ Unable to hold urine _____ Impotence
_____ Blood in urine _____ Kidney stones _____ Sores on genitals
_____ Discharge (Color) _____ Pain with intercourse _____ Genital pain

What color is your first urine in the morning?

Other urogenital conditions:

MEN ONLY

_____ Hernias _____ Testicular masses _____ Testicular pain
_____ Prostate problem _____Erectile dysfunction _____Premature ejaculation

Date and results of last prostate exam:

GYNECOLOGICAL

Age at first menses _____ Age at menopause _____
Are you pregnant? (Yes / No)
# of live births _____ # of abortions _____ # of miscarriages_____
Length of cycle _____ Duration of bleeding _____ 1st day of last period _____
Do you use birth control? If so, what type and for how long?
What color is your menstrual flow?
Is there pain accompanying your menstruation? Before, during or after?
Nature of menstrual pain:
□Cramping □Stabbing □Burning □Dull □Bloating □Consistent □Intermittent

Symptoms Related to Menses:
□Discharge □Moodswings □Headache □Insomnia □Decreased libido □Increased libido □Constipation □Diarrhea □Vaginal dryness □Nightsweats □Hot flashes □Nausea □Poor appetite □Increased appetite □Breast lumps □Swollen or tender breasts

When do you feel these symptoms more: before, during or after the menstruation?

Date and results of last gynecological exam/ mamogram:

Other gynecological conditions:

ENDOCRINAL, NEUROLOGICAL, AND PSYCHOLOGICAL

_____ Seizures	_____ Fainting	_____ Poor memory
_____ Dizziness	_____ Lack of coordination	_____ Loss of balance
_____ Tingling/numbness	_____ Motor loss or weakness	_____ Tremors
_____ Sweating easily	_____ Temperature imbalance	_____ Thyroid problem
_____ Diabetes	_____ Anxiety	_____ Depression
_____ Easily angered	_____Mood swings	_____Hallucinations

Do you feel like harming or killing yourself or someone else at this time? (Yes / No)

Other endocrinal, neurological or psychological conditions: