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ACUPUNCTURE & ORIENTAL MEDICINE

HEALTH QUESTIONNNAIRE

Note: Information provided on this form is confidential.
To facilitate the process of Traditional Chinese Medical pattern diagnosis and determining the best treatment(s) to assist in your healing process, it is important that the information you provide be as complete as possible.

PATIENT NAME: _____

Date: _____

Age: _____ Date of Birth: _____ Gender (circle): M / F

Marital Status: _____Single _____Married _____Divorced _____Widowed

Occupation: _____

Medication Allergies: _____

Food or Environmental Allergies: _____

Describe your allergic symptoms or signs: _____

_____

FOCUS OF TREATMENT

(Describe your symptoms or health issue for which you are seeking treatment.)

_____

_____

How long have you had this condition? _____. The onset was: Sudden ____ / Gradual ____

Symptoms are relieved or improved by_____.

Symptoms are worsened by_____.

What medical diagnosis have you received for this condition? _____

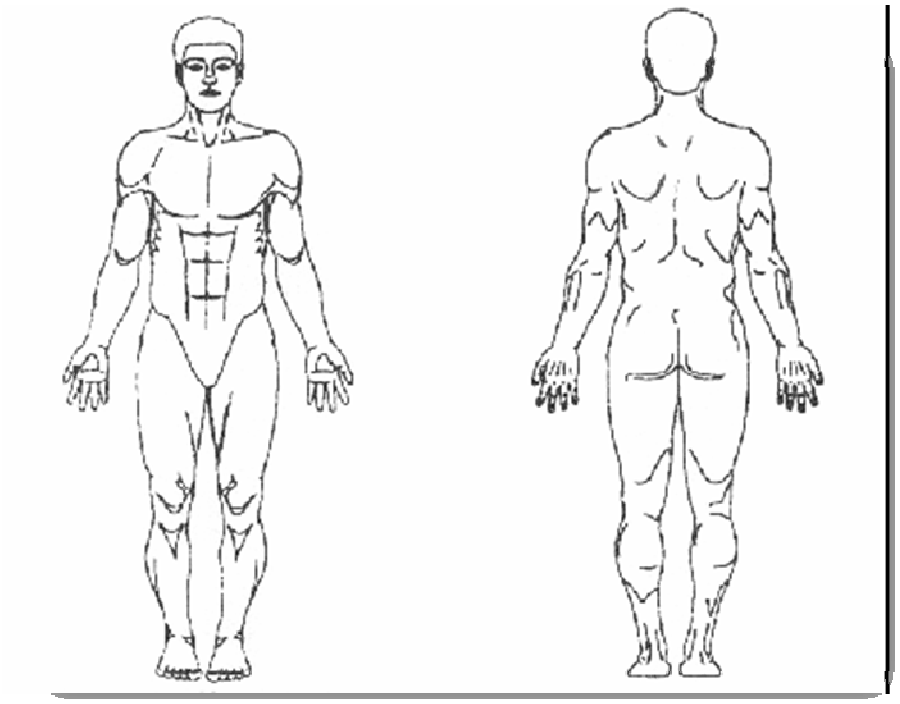
What other treatments have you received for this condition? _____

_____

Can you relate the onset of your symptoms to any major event, or any change in lifestyle? (For example, a change in: diet, exercise, occupation, sleep, stress level, relationship, personal loss, etc.)

Describe: _____

On the following drawings, shade in the areas where you feel should be addressed.



IF YOU HAVE PAIN, please check words that best describe your pain:

____Sharp ____Stabbing ____Dull ____Throbbing ____Diffuse ____Focused ____Aching

____Sore ____Burning ____Itching ____Shooting, nerve-like pain ____Tingling or numbness

____Intermittent (comes and goes) ____Continuous

____Location of pain moves from place to place, or is difficult to locate

____Radiating (starts in one area and spreads to another)

Please add other descriptive words if the above do not describe your pain:

_____

Is your pain accompanied by **weakness** or **loss of function**? Yes / No

Accompanied by **redness**, **swelling**, or other **change in appearance** of affected part? Yes / No

Please describe _____

Please mark on the scale of 1 to 10, the number that represents the **Severity of your pain**:

EXAMPLE (Not painful at all) **1**_____7_____**10** (worst pain ever felt)

YOUR PAIN: (Not painful at all) **1**_____**10** (worst pain ever felt)

Please list your CURRENT MEDICATIONS

Medication Name	Dosage	For What Condition?	How long have you been taking this medication?

List any Herbs or other Supplements you are taking:

Herb, Supplement or Vitamin	Dosage	For What Condition?	How long have you been taking this?

Please describe any CURRENT THERAPIES you are undergoing:

Have you ever had acupuncture in the past? Yes / No

If yes, did you have regular treatments for a period of time? Yes / No For how long ?_____.

What was your response? _____.

Have you ever taken Traditional Chinese Herbal Formulas? Yes / No

Have you ever taken recreational, or non-medical drugs? YES / NO

Have you ever taken hormones, either 'over the counter' or prescription? YES / NO

Women:

Are you currently pregnant? Yes / No

Are you presently trying to get pregnant? Yes / No

YOUR PAST MEDICAL HISTORY

Circle any **childhood illnesses** you have had:

Measles, mumps, rubella, whooping cough, chickenpox, rheumatic fever, scarlet fever, polio.

Other_____

List any **surgeries,** or **hospitalizations**, and **dates** these occurred. _____

_____

Health Maintenance: Yearly Physical _____ Visual Exams_____ Dental Exams_____

If over 50, have you had a Colonoscopy? ____ BP checked? _____ Recent Blood Tests?_____

Adult Illnesses or **Diagnoses**	**Check if YES**	**Age or date** of illness / diagnosis	Please circle the appropriate choice:
Cardiovascular disease			On medication / Resolved / Neither
Hypertension			On medication / Resolved / Neither
Diabetes			On medication / Resolved / Neither
Thyroid disease			On medication / Resolved / Neither
Respiratory Illness			On medication / Resolved / Neither
GERD			On medication / Resolved / Neither
Colitis or IBS			On medication / Resolved / Neither
Hepatitis / Liver Disease			On medication / Resolved / Neither
Urinary tract infections			On medication / Resolved / Neither
Kidney disease			On medication / Resolved / Neither
Arthritis / Gout			On medication / Resolved / Neither
Osteoporosis			On medication / Resolved / Neither
Hernia			On medication / Resolved / Neither
Cancer			On treatment / Resolved / Neither
Autoimmune Disorder			On medication / Resolved / Neither
HIV / AIDS			On medication / Resolved / Neither
Neurological Disorder			On medication / Resolved / Neither
Headaches/ Migraines			On medication / Resolved / Neither
Mental/ Emotional			On medication / Resolved / Neither
Others not listed:			
			On medication / Resolved / Neither
			On medication / Resolved / Neither

If you answered YES to any of the above, please give **additional details**:

_____

_____

YOUR FAMILY HISTORY – **Please indicate whether any family members have had any of the illnesses listed in the Past Medical History section, or others**. List or describe in the space provided.

Father	
Paternal GF	
Paternal GM	
Mother	
Maternal GF	
Maternal GF	
Aunts	
Uncles	
Siblings	
Children	

Please continue to Page 6

Traditional Chinese Medical diagnosis attempts to determine underlying patterns in your constitution and health condition. In order to identify these patterns, we need to ask questions that may seem unrelated to your condition. However, your answers are very important for your acupuncturist to be able decide on the proper treatment.

Please circle any symptoms you have experienced recently, to a significant degree, or frequently, over a longer time period:

TEMPERATURE & THIRST

Feel cold often Feel hot/ warm often Hot flashes Heat intolerance Cold extremities

Sweating at night Excessive sweating Frequently thirsty

No thirst Desire cold drinks Desire warm drinks Thirsty but can't drink much

ENERGY, SLEEP and EMOTIONS

Fatigue Tired in the morning Tired in the afternoon Tired after meals

Best energy in morning Best energy at night Excessive Energy Lack of motivation

Insomnia: Difficulty falling asleep Frequent awakening Early am awakening

Irritable/ restless sleep Frequent, vivid dreams Nightmares

Easily Angered Impatient Unable to relax Depressed Hyperactive Anxious

Perfectionist Obsessive thinking Sadness Unresolved grief Fears or phobias

HEAD, FACE & SENSES:

Dizziness Difficult concentration Poor memory Mental "fog"

Headaches or migraines Describe:_____

Blurry Vision See spots/floaters Painful/red eyes Dry Eyes Itchy or Watery eyes

Sinus congestion Sinus pain Allergies Runny nose Nose bleeds

Ear pain Ringing in ears Clogged/popping in ears Hearing loss

Dry mouth Cold sores Mouth Sores Bleeding gums Breath odor

Dry throat Sore throat: Frequent/ Mild/ Severe Hoarseness

CHEST & CARDIO

Frequent colds Chest congestion Dry cough Cough with phlegm (Color: _____)

Shortness of breath on exertion Shortness of breath at rest Asthma

Chest pain Chest tightness Palpitations Pain in sides or ribs

ABDOMEN & DIGESTION

Reflux (GERD) Stomach pain Nausea Vomiting Belching Colic

Gas Bloating Constipation Diarrhea Painful bowel movements Hemorrhoids

DIET & HUNGER

Lack of appetite Frequent hunger Excessive appetite Hungry but can't eat

Eating disorder Food intolerances _____

Crave foods that are: Sweet Salty Sour Bitter Spicy Meaty Carbohydrates

URINATION

Difficult Frequent Urgent Painful Scanty Profuse

Incontinence or leaking Weak stream Strong odor

Urine Color: Clear/ pale Yellow Cloudy Dark Pink or with blood

Other: _____

MUSCLES, BONES & JOINTS

Weakness Muscle wasting Heavy limbs Decreased mobility

Spinal problems Osteoporosis Fractures Joint pain Joint swelling

Weak or sore back Weak or sore knees Hot, inflamed joints

EXTREMITIES: Numbness Tingling Bluish or white extremities Hot palms and soles

REPRODUCTIVE – <u>MEN ONLY</u>

Prostate Enlargement Prostate Cancer Testicular Pain Inguinal Hernia

Low Libido Decreased Sexual Function History of fertility problems

History of STD Genital Rash or other inflammation Other _____

Please skip to bottom of Page 8

REPRODUCTIVE – WOMEN ONLY

Age of onset of menses: _____.

How many: Pregnancies_____, Births_____, Miscarriages or Therapeutic Abortions_____.

Are you on birth control pills (BCP's)? YES / NO. If YES, what type and dosage? _____.

For how long?_____.

Do you use another type of birth control? If so, what type?_____.

Are you post-menopausal? YES / NO.

Hormonal Replacement (HRT)? YES /NO. What type? _____. For how long? _____.

Do you have an annual gynecology exam and Pap screening done regularly? YES / NO

Any history of vaginal infections, STD's or other inflammatory condition?_____.

Do you do Breast Self-Exams? Circle: Never Rarely Monthly Weekly

If you are age 40 or older, are you current with annual screening mammograms? YES / NO

Ever had an abnormal result on a Mammogram? _____. On a Pap test? _____.

If you currently have periods, please answer the following questions regarding your menstrual pattern.

If you are postmenopausal, please answer the questions regarding your menstrual pattern in the past.

Average Cycle length (from 1st day of period to 1st day of next period): _____days.

Average days of flow:_____ days.

I have or had (check all that apply):

Irregular periods Medium flow Light flow Heavy flow Painful periods Clots

PMS or Discomfort before period (describe): _____

Fatigue or other symptoms: During period _____. After period _____

Spotting between periods Vaginal itching/burning Vaginal discharge (Color_____)

History of: uterine fibroids ovarian cysts endometriosis fertility problems STD PID

Other_____

ALL PATIENTS:

If there is anything else that you wish to let us know about, ask about, or to have addressed in your treatment, please include additional information or questions here:

_____

_____

Thank you!