Nourishing Life Acupuncture & Chinese Herbal Medicine

Health History Questionnaire

Name:		Date:
Street Address:		
City:	State:	Zip:
Home phone:	Work phone:	Cell:
**** Please mark preferred contact number for reminder calls with a star ****		
Email:		
Date of Birth:	Place of Birth:	Age:
Employer Name:		
In emergency, please notify:		Phone:
How did you hear about our office?		
Have you been treated by acupuncture before?		Chinese herbal medicine?

Reason #1 for contacting our office:_____
_____
Date of injury:_____If not an injury when did the problem begin?_____
Please describe your symptoms and what makes them better or worse:_____
_____
_____
_____
_____
Has a medical diagnosis been given for this problem?_____
Previous treatments you have tried and the results:_____
_____
_____

Reason #2 for contacting our office:_____
_____
Date of injury:_____If not an injury when did the problem begin?_____
Please describe your symptoms and what makes them better or worse:_____
_____
_____
_____
_____
Has a medical diagnosis been given for this problem?_____
Previous treatments you have tried and the results:_____
_____
_____

Please download and fill out a **Functional Rating Index** for each Condition listed above.

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Last Doctor's appointment (date & reason for visit): _____

Please circle the following that apply to you:

Pregnant	Bleeding Disorder	Pacemaker	Hepatitis	Seizures
HIV	High Blood Pressure	Surgical Mesh	Chemo/Radiation	

Please describe any allergies and reactions (drugs, chemicals, foods, or environmental):

_____

_____

_____

Medication/Vitamins/Supplements/Herbs:	Reason for taking it:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is your history for major
Illnesses/Traumas:_____

_____

Surgeries:_____

_____

Family Medical History (stroke, heart disease, high blood pressure, cancer, skin disease, mental disorders, seizures, asthma, substance abuse, allergies, diabetes, etc.):

Father:_____

Mother:_____

Siblings:_____

Grandparents:_____

Are you on a restricted diet? Yes No Please describe:_____

_____

_____

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Health History Questionnaire

Please circle the appropriate number to describe the amounts consumed each day:

0 1 2 3 4 5

none ---------- heavy

Wheat products (bread, pasta, pastries, etc)……0	1	2	3	4	5
Grains & legumes……0	1	2	3	4	5
Dairy products (milk, cheese, butter)…… 0	1	2	3	4	5
Seafood (fish & shellfish)……0	1	2	3	4	5
Animal products (meats, poultry, eggs)……...0	1	2	3	4	5
Cooked vegetables……..0	1	2	3	4	5
Raw vegetables……0	1	2	3	4	5
Water……0	1	2	3	4	5
Sugar……0	1	2	3	4	5
Salt……0	1	2	3	4	5
Processed foods……...0	1	2	3	4	5

Please describe your habits by filling in the amount and frequency (daily, weekly, monthly):
Cigarettes:_____per_____ Marijuana_____per_____ Alcohol_____per_____
Tea_____per_____ Coffee_____per_____ Soft Drinks_____per_____

What is your work and do you enjoy it?_____
If not working, what are your main activities?_____
What do you consider your current stress level to be on a scale of 1-10?_____
What are the major stress factors in your life?_____
What do you do to relieve stress or relax?_____
How much time a day do you watch TV/movies?_____Spend on the computer?_____
Do you have a regular exercise program? Yes No Please describe:_____
_____
What time do you fall asleep? _____Wake?_____Number of hours a night?_____
How long does it take you to fall asleep? _____Do you wake feeling rested?_____
Do you wake during the night? _____ # of times:_____Reason:_____
Do you nap or rest during the day? _____ If so for how long? _____
Please rate your general energy level on a scale of 1-10 (one being the lowest):_____
What time of day is it the highest? _____ Lowest?_____

Emotions have physical effects on health; please rate your daily emotions on a scale of 1-5:

Anger……0	1	2	3	4	5
Frustration……0	1	2	3	4	5
Joy/Happiness……0	1	2	3	4	5
Worry/Anxiety……0	1	2	3	4	5
Sadness……..0	1	2	3	4	5
Fear/Phobias……0	1	2	3	4	5
Contentment……0	1	2	3	4	5

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General:

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Fatigue
- ☐ Night sweats
- ☐ Strong thirst (for hot or cold)
- ☐ Thirst, but no desire to drink
- ☐ Cravings, for what: _____
- ☐ Change in appetite

Skin and Hair:

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Other, please specify: _____

Head, eyes, ears, nose and throat:

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Teeth grinding
- ☐ Teeth problems
- ☐ Eyes strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks, aches
- ☐ Migraine
- ☐ Eye pain
- ☐ Sores on lips or inside mouth
- ☐ Earaches
- ☐ Spots in front of the eyes
- ☐ Recurrent sore throats
- ☐ Headaches, where on head: _____

Cardiovascular:

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands and feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty breathing
- ☐ Other heart or blood vessel problems: _____

Respiratory:

- ☐ Cough
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ Asthma
- ☐ Pain on breathing
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Allergies
- ☐ Rhinitis
- ☐ Difficulty breathing lying down
- ☐ Tight chest
- ☐ Shortness of Breath (on exertion; walking, climbing stairs, exercising, etc.)
- ☐ Coughing or blowing nose w/ phlegm: what color? _____
- ☐ Other lung or breathing problems: _____

Gastrointestinal:

- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems: _____

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Health History Questionnaire

Genito-Urinary:

- □ Pain on urination
- □ Urgency to urinate
- □ Decrease in flow
- □ Unable to hold urine
- □ Difficulty urinating
- □ Kidney stones
- □ Blood in urine
- □ Sores on genitals

Musculoskeletal:

- □ Neck pain
- □ Back pain
- □ Hand/wrist pain
- □ Muscle pain
- □ Muscle weakness
- □ Shoulder pain
- □ Knee pain
- □ Foot/ankle pain
- □ Hip pain
- □ Other: _____

Neuropsychological:

- □ Seizures
- □ Areas of numbness
- □ Concussion
- □ Bad temper
- □ Dizziness
- □ Lack of concentration
- □ Depression
- □ Loss of balance
- □ Easily susceptible to stress
- □ Poor memory
- □ Anxiety

For women only:

- □ Sweet cravings
- □ Nervousness
- □ Took birth control pills
- □ Heavy period
- □ Tender breasts before period
- □ PMS
- □ Fluid retention
- □ Mood swings
- □ Decreased sex drive
- □ Habitual miscarriage
- □ Infertility
- □ Vaginal discharge
- □ Scanty menses
- □ Heavy menses
- □ Breast pain
- □ Uterine fibroids
- □ Breast lumps
- □ Uterine hemorrhage
- □ Irregular period
- □ No period

Age when started menses: _____ Age when started menopause: _____

Pregnancies: _____ Age: _____

Miscarriages: _____ Age: _____

Abortions: _____ Age: _____

For men only:

- □ Decreased sex drive
- □ Impotency
- □ Low sperm count
- □ Exhaustion after sex
- □ Difficult urination
- □ Nighttime urination
- □ Scanty ejaculation
- □ Premature ejaculation
- □ Loss of force when urinating
- □ Dribbling after urination

Please tell me about any other conditions that you would like to address:_____

_____

_____

_____

Privacy Policy

As mandated by Federal and State legal requirements, your health information must be protected. As part of these regulations, we are required to ensure that you are aware of our privacy practices.

Your health information may be shared between providers within Nourishing Life.
Your health information will be released to another healthcare provider only if you have requested it in writing. It may be used and disclosed to obtain payment for services Nourishing Life has provided to you. We also will use your information to assist you with appointment reminders.

Informed Consent for Treatment

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including; bruising, numbness, or tingling near the needling sites that may last a few days, dizziness and fainting. Bruising is a common side effect of cupping, and burning and/or scarring are potential risks of moxibustion.

I understand that some herbs may interact with prescription drugs, over-the-counter medications, or supplements, and as such I will notify Nourishing Life if I am taking any medication or supplements concurrently with Chinese Herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify Nourishing Life if I am or become pregnant. Patients with bleeding disorders, pace makers, or surgical mesh should inform us prior to any treatment.

I do not expect Nourishing Life to be able to anticipate and explain all possible risks and complications of treatment. I understand that the results are not guaranteed. I understand that Nourishing Life is not providing Western (Allopathic) medical care, and that I should look to my Primary Care Provider (MD, ND, or DO) for those services and for routine check-ups.

I understand the acupuncture treatments are my financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. I will provide Nourishing Life with at least 24 hours notice if I need to reschedule or cancel an appointment and I understand that I will be charged a fee for any appointment cancelled or changed with less than 24 hours notice. I also understand that my insurance will not cover the fee for missed appointments.

Signature of Patient or Guardian _____ Date _____