Essential Health Acupuncture
Susana Byers, Lic. .Ac.

COMPREHENSIVE HEALTH HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Name_____ Today's Date_____

Address_____ Date of Birth_____Age_____

City/Zip_____ Place of Birth_____

Home Phone_____ Height_____ Weight_____

Mobile Phone_____ Gender:_____

Business Phone_____ Emergency Contact:

Email_____ Name_____

Occupation_____ ___ Relationship_____

May we email you ? ☐ Yes ☐ No Phone #_____

REFERRAL INFORMATION

Who should we thank for referring you to this office?

_____

PHYSICIAN INFORMATION

Name of Dr._____ Date of last Physical Exam_____

Address_____

Phone_____

REASONS FOR YOUR VISIT

Please list the main health concerns you would like to address:

_____

_____

_____

PREVIOUS ACUPUNCTURE EXPERIENCE

Have you had acupuncture before? Yes_____ No_____

Practitioner: _____

PERSONAL HEALTH HISTORY

Surgeries, Major Illnesses, Hospitalizations and Major Accidents:

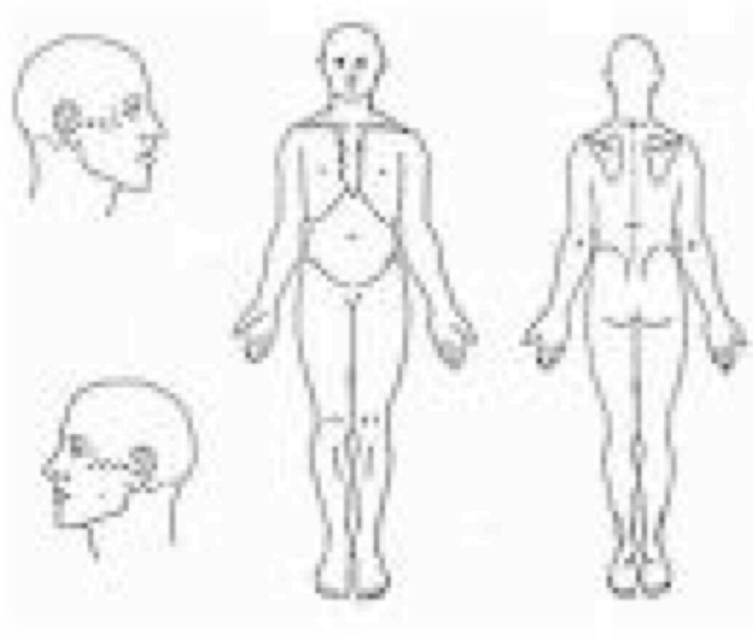
Have you or anyone in your family suffered from the following illnesses? Please indicate which blood relative: grandparent (GP), parent (Mom,/Dad), sibling (Bro/Sis), child (C)

	You	Relative		You	Relative
☐ Allergies			☐ Arthritis		
☐ Asthma			☐ Osteoporosis		
☐ Diabetes			☐ Alzheimer's		
☐ High Blood Pr			☐ Parkinson's		
☐ Heart Disease			☐ Fibromyalgia		
☐ Stroke			☐ Chr. Fatigue		
☐ Seizures			☐ Mental Illness		
☐ Cancer			☐ Addiction		
☐ Hepatitis			☐ IBS		
☐ Herpes			☐ Thyroid Disorder		
☐ HIV +			☐ Kidney Stones		
☐ AIDS			☐ Gall Stones		
☐ Other STD			☐ Other		

Please add relevant detail to above illnesses (i.e. type of cancer, dates, etc):

Ages of death: Mother _____Father _____Brother (s) _____Sister(s)_____

PHYSICAL PAIN AND SCARS



Please indicate painful areas with "X" and scars with and "S."

When do you feel the pain?

_____

How long have you felt pain?_____

Is the pain:
☐ Dull and Aching
☐ Sharp and Stabbing

What makes the pain worse? _____

What relieves the pain?
_____

Please add any other info about your pain/scars that you feel is important:

FOR MEN ONLY

Date of last Prostate check up _____ PSA results_____

Manual Prostate exam results_____

Lab Results_____

Frequency of urination: Daytime_____ Nighttime_____

Color of urine: _____ ☐ Clear ☐ Murky ☐ Odor_____

Have you experienced the following:

☐ Prostate problems ☐ Delayed Stream ☐ Dribbling ☐ Incontinence ☐ Infertility

☐ Retention of Urine ☐ Rectal Dysfunction ☐ Impotence ☐ Premature Ejaculation

☐ Increased libido ☐ Decreased libido ☐ Back Pain ☐ Groin Pain ☐ Testicular Pain

☐ Other _____

Please describe anything else significant related to your genitourinary health:

FOR WOMEN ONLY

Age of 1st period _____

Age of last period/menopause _____

Number of days btw periods _____

Number of days of flow_____

Color of Flow _____

Clots: ☐ Yes ☐ No

Color/Size_____

Are you pregnant: ☐ Yes ☐ No

Births___ Miscarriages___ Abortions ____

Birth Control Pill : ☐ Yes ☐ No

Infertility: ☐ Yes ☐ No ☐ Maybe

Date of last GYN exam: _____

Pap smear results_____

Mammogram results _____

Have you been diagnosed with the following:

☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts

☐ PID ☐ Other _____

Do you experience menstrual pain or PMS : ☐ Yes ☐ No

Location of Pain: ☐ Lower Abdomen ☐ Low Back ☐ legs ☐ Other:_____

Nature of pain (Please indicate Before, During, or After Menses)

- Cramping_____ Stabbing _____ Burning_____

Dull_____ Aching_____ Intermittent_____

Do you experience any of the following symptoms before or during your period?

☐ Water Retention ☐ Bloating ☐ Breast Tenderness or swelling ☐ Irritability

☐ Food Cravings ☐ Migraines ☐ Emotional Upset ☐ Acne ☐ Other _____

Please indicate if you are experiencing any of the following:

☐ Night sweats ☐ Vaginal dryness ☐ Insomnia ☐ Increased libido ☐ Decreased libido

Please describe anything else significant related to your menses:

BODY SYSTEMS REVIEW (Please check all that apply)

0 = Never 1= in the past but not now 2 = occasionally
3= frequently 4= almost always

0 1 2 3 4 low appetite	0 1 2 3 4 heavy limbs
0 1 2 3 4 1oose stools	0 1 2 3 4 fatigue
0 1 2 3 4 abdominal gas/bloating after food	0 1 2 3 4 hemorrhoids
0 1 2 3 4 fatigue after eating	0 1 2 3 4 belching
0 1 2 3 4 organ prolapse	0 1 2 3 4 nausea
0 1 2 3 4 bruise easily	0 1 2 3 4 diarrhea
0 1 2 3 4 obsessive thoughts/worrying	0 1 2 3 4 craving for sweets
0 1 2 3 4 spontaneous sweat	0 1 2 3 4 feeling of sadness
0 1 2 3 4 allergies	0 1 2 3 4 catch cold easily
0 1 2 3 4 asthma	0 1 2 3 4 feel tired after exercise
0 1 2 3 4 shortness of breath	0 1 2 3 4 constipation
0 1 2 3 4 cough	0 1 2 3 4 nasal discharge
0 1 2 3 4 dry nose/mouth/skin/throat	0 1 2 3 4 sinus congestion
0 1 2 3 4 sore, cold, or weak knees	0 1 2 3 4 feeling cold
0 1 2 3 4 low back pain	0 1 2 3 4 edema
0 1 2 3 4 frequent urination	0 1 2 3 4 hair loss
0 1 2 3 4 urinary incontinence	0 1 2 3 4 memory loss
0 1 2 3 4 ear problems	0 1 2 3 4 hot flashes
0 1 2 3 4 early morning diarrhea	0 1 2 3 4 night sweats
0 1 2 3 4 craving salt	high low normal libido
0 1 2 3 4 irritable	0 1 2 3 4 muscle spasms/twitches
0 1 2 3 4 feel better after exercise	0 1 2 3 4 heartburn/acid reflux
0 1 2 3 4 tight feeling in chest	0 1 2 3 4 dry eyes/red eyes
0 1 2 3 4 alternating diarrhea/constipation	0 1 2 3 4 ear ringing
0 1 2 3 4 symptoms worse with stress	0 1 2 3 4 anger easily
0 1 2 3 4 neck/shoulder tension	0 1 2 3 4 sand in eyes
0 1 2 3 4 floaters in vision	0 1 2 3 4 hair loss
0 1 2 3 4 brittle or weak nails	0 1 2 3 4 frequent headaches
0 1 2 3 4 feeling of heat rushing to head	0 1 2 3 4 blurry vision
0 1 2 3 4 feel heart beating	0 1 2 3 4 chest pain
0 1 2 3 4 insomnia	0 1 2 3 4 disturbing dreams
0 1 2 3 4 sores on tip of tongue	0 1 2 3 4 excessive laughter
0 1 2 3 4 anxiety	0 1 2 3 4 palpitations
0 1 2 3 4 restlessness	0 1 2 3 4 excessive sweat
0 1 2 3 4 red cheeks	0 1 2 3 4 canker sores

DIET AND LIFE STYLE

Describe what you eat?_____

_____

_____

_____

Food Cravings?_____

Food Sensitivities?_____

How many cups/glasses do you drink each day of the following:

Water_____ Soda_____ Coffee_____ Tea_____ Alcohol_____

Do you smoke? ☐ Yes ☐ No If yes, how many per day? _____

Describe any recreational drug use_____

Exercise? ☐ Yes ☐ No How often? _____

Type?_____

Sleep: Hours per night_____ Trouble falling asleep? ☐ Yes ☐ No ☐ Sometimes

Trouble sleeping a full night? ☐ Yes ☐ No If yes, describe_____

_____

Work: Enjoy Work? ☐ Yes ☐ No ☐ Sometimes Hours per week working_____

ELIMINATION

Urination: ☐ Burning ☐ Urgent ☐ Retention ☐ Frequent ☐ Cloudy ☐ Dark ☐ Pale ☐ Scanty ☐ Profuse ☐ Dribbling

Do you urinate more than 1X a night: ☐ Yes ☐ No

Bowel Movements: Frequency_____ When?_____

Feels complete? ☐ Yes ☐ No

In stools? ☐ Undigested food ☐ Blood ☐ Mucus

Consistency: ☐ Well-formed ☐ Hard ☐ Loose ☐ Alternates

MEDICATIONS/SUPPLEMENTS

Please list your current medications and supplements including vitamins?

Prescription/Supplement	**Reason**	**Dosage**	**How Long?**

Please describe anything else you would like to mention about your health,?

Essential Health Acupuncture
Susana Byers, Lic. .Ac.

Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist immediately.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation.

_____ Date_____
Patient's Name

_____ Are you pregnant?_____
Signature of Patient or Guardian

_____
Practitioner's Signature