

Women's Wellness Center

Questionnaire for Acupuncture or Chinese Herbal Medicine Consultation

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Women's Wellness Center

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Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but may play a major role in your diagnosis and treatment.
All information is strictly confidential.

PATIENT INFORMATION	
Name _____	Age _____ Birthdate _____ Date _____
HEALTH HISTORY	
What are your primary concerns for coming in for treatment? <i>List in order from greatest to least significant.</i> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ How do these conditions impair your daily activities? _____ _____	List medications or food supplements you are taking. _____ _____ For what conditions are they used? (<i>in respective order</i>) _____ _____ Results: _____ _____
What conditions significantly affected your health as a child _____ _____ _____	List serious illness, accidents or surgeries. _____ _____ _____
Check illnesses that have occurred in blood relatives: <input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Heart Disease	Check symptoms you have or have had in the last year: <input type="checkbox"/> Depression <input type="checkbox"/> Fatigue/tiredness <input type="checkbox"/> Difficulty in focusing <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of sleep/poor sleep <input type="checkbox"/> Easily startled <input type="checkbox"/> Loss/gain of weight <input type="checkbox"/> Excessive worry <input type="checkbox"/> Nervousness <input type="checkbox"/> Excessive anger <input type="checkbox"/> Irritability <input type="checkbox"/> Excessive fear <input type="checkbox"/> Overwhelmed by life
Check conditions you have or have had in the past: <input type="checkbox"/> Allergies <input type="checkbox"/> Diabetes <input type="checkbox"/> Anemia <input type="checkbox"/> Heart Disease <input type="checkbox"/> Arthritis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Breast lump <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> AIDS	

Continued on other side

Check symptoms you have or have had in the past year:

MUSCLE/JOINT/BONES

- Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms
- Legs or Hips
- Feet
- Neck
- Hands
- Shoulders
- Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

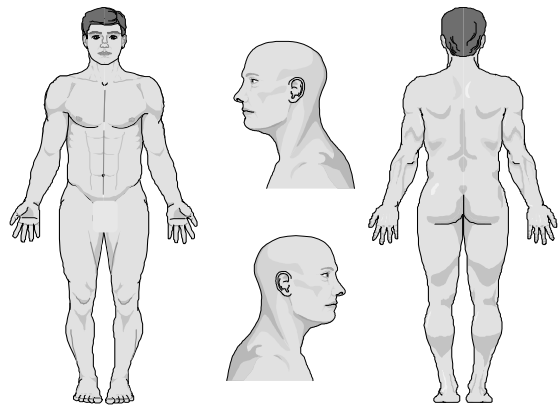
SKIN

- Boils
- Bruise easily
- Dry Skin
- Itching/rash
- Sensitive skin
- Sore that won't heal
- Sweats

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

On the figure below, please mark clearly any areas of pain



GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stone
- Low/High libido

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Indigestion
- Nausea/Vomiting
- Pain over stomach
- Poor Appetite

FOR MEN ONLY

- Erection difficulties
- Prostate trouble
- Penile discharge

FOR WOMEN ONLY

- Bleeding between periods
- Excessive menstrual flow
- Extreme menstrual pain
- Menopausal symptoms
- Previous miscarriage
- Scanty menstrual flow
- Clots in menses
- PMS
- Irregular cycle

Could you be pregnant? _____

SIGNATURE *The information on this form is correct to the best of my knowledge.*

Signature: _____ Date _____