Women's Wellness Center

Questionnaire for Acupuncture or Chinese Herbal Medicine Consultation

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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? *List in order from greatest to least significant.*
1._____
2._____
3._____
4._____
5._____

How do these conditions impair your daily activities?
_____
_____
_____

What conditions significantly affected your health as a child_____
_____
_____

List medications or food supplements you are taking.
_____
_____
_____

For what conditions are they used? *(in respective order)*
_____
_____
_____

Results:_____
_____
_____

List serious illness, accidents or surgeries.
_____
_____
_____

Check illnesses that have occurred in blood relatives:
❑ Diabetes ❑ High Blood Pressure ❑ Stroke
❑ Cancer ❑ Kidney Disease ❑ Heart Disease

Check conditions you have or have had in the past:
❑ Allergies
❑ Anemia
❑ Arthritis
❑ Bleeding disorder
❑ Breast lump
❑ Cancer
❑ Diabetes
❑ Heart Disease
❑ High Blood Pressure
❑ Multiple Sclerosis
❑ Stroke
❑ AIDS

Check sympoms you have or have had in the last year:
❑ Depression
❑ Difficulty in focusing
❑ Dizziness
❑ Easily startled
❑ Excessive worry
❑ Excessive anger
❑ Excessive fear
❑ Fatigue/tiredness
❑ Headaches
❑ Loss of sleep/poor sleep
❑ Loss/gain of weight
❑ Nervousness
❑ Irritability
❑ Overwhelmed by life

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
- ❑ Hoareness
- ❑ Gum trouble
- ❑ Nose bleeds
- ❑ Loss of hearing
- ❑ Persistant cough
- ❑ Ringing in ears
- ❑ Sinus problems

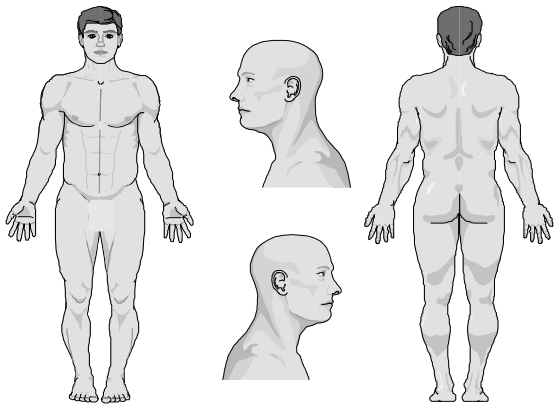
SKIN

- ❑ 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
- ❑ Inablilty 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
- ❑ Penile discharge
- ❑ Prostate trouble

FOR WOMEN ONLY

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

Could you be pregnant?_____

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

Signature:_____Date_____