Acupuncture Health History Questionnaire

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (C) _____ (W) _____

E-Mail: _____ Emergency Contact: _____

Place of Birth: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Referred By: _____ Family Physician: _____

Occupation: _____

Have you been treated by acupuncture before? _____

In order of priority name 5 problems you like for us to help you with. _____

_____

To what extent do these problems interfere with daily activities, (work, sleep, sex)? _____

_____

What types of treatment have you tried? _____

_____

Have you been given a diagnosis for this problem and if so what? _____

_____

Medical history: (please include dates). _____

_____

Current Illnesses: (please circle) Cancer Diabetes Hepatitis Seizures High Blood Pressure Rheumatic Fever

Thyroid Disease Venereal Disease Others: _____

Any Trauma? (Auto accidents, falls, etc.) _____

Your Birth History: (prolonged labor, forceps delivery, etc.) _____

Allergies:(medication, chemicals, food) _____

Family Health History: Cancer Asthma Stroke High Blood Pressure Seizures Allergies Diabetes Heart Disease

Medication taken within the last two months (vitamins, drugs, herbs, etc.) _____

_____

Occupation & Occupational Stress (chemical, physical, psychological)? _____

Do you have a regular exercise program? Please describe _____

Have you ever been on a restricted diet? _____ What type? _____

AcuWellness Atlanta
550 Pharr Rd., NE, Suite 410
Atlanta, GA 30305
404-841-9994

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Please describe your average daily diet: _____

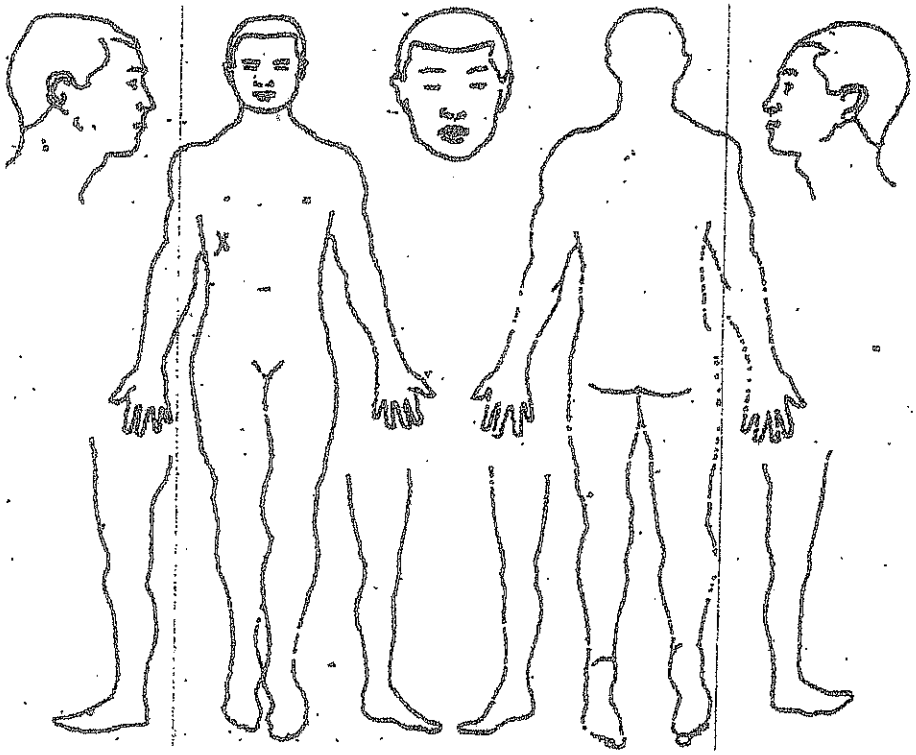
Do you smoke, how much? _____ **Do you drink coffee/tea or cola and how much?** _____

Do you drink alcohol and how much? _____

Please describe any use of drugs for non-medical purposes: _____

_____

Please indicate painful or distressed areas and rate the pain level 1 to 10. _____



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***Females Only*: Pregnancy and Gynecology**

Number of pregnancies: ___ Number of births:____ Premature births:____ Miscarriages: _____

Abortions: _____ Age at first menses: ___ Time between menses: Duration: _____

Irregular periods? _____ Painful periods? _____ Clots? _____ Date of last PAP? _____

First date of menses: ____ Vaginal discharge? ___ Vaginal sores? _____ Breast Lumps? _____

Unusual (heavy/light?) _____

Changes in body /psyche prior to menstruation: _____

Do you practice birth control? _____ What type and for how long? _____

Genital-Urinary: Please circle if applicable and rate the pain/occurrence from 1 to 10

Pain on urination ___ Frequent urination ___ Blood in urine ____ Urgency to urinate _____ Kidney Stones ___

Unable to hold urine _____ Decrease in flow _____ Impotency ____ Sores on genitals

Do you wake from sleep to urinate? _____ How often? _____ Any particular color to your urine? _____

Any other problems with your genital or urinary system? _____

Gastrointestinal: Please circle if applicable and rate the pain/occurrence from 1 to 10

Nausea _____ Vomiting _____ Diarrhea _____ Constipation _____ Gas _____ Belching _____

Black stools _____ Blood in stools _____ Indigestion _____ Bad breath _____ Rectal Pain ____

Hemorrhoids _____ Abdominal pain or cramps _____

Any other problems with your stomach or intestines? _____

_____

Musculoskeletal: Please circle if applicable and rate the pain/occurrence from 1 to 10

Neck pain _____ Back pain _____ Muscle pain _____ Hand / Wrist Pain _____ Shoulder Pain _____

Muscle weakness _____ Foot / Ankle pain _____ Hip pain _____

Any other joint or bone problems? _____

_____

Psychological: Please circle if applicable and rate the pain/occurrence from 1 to 10

Seizures _____ Dizziness _____ Loss of balance _____ Areas of numbness _____ Poor Memory ____

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Cardiovascular: Please circle if applicable and rate the pain/occurrence from 1 to 10

High blood pressure _____ Low blood pressure _____ Chest pain _____ Irregular heartbeat _____

Dizziness _____ Fainting _____ Cold hands or feet _____ Swelling of hands _____ Swelling feet ___

Blood clots _____ Phlebitis _____ Difficulty in breathing _____

Any other heart or blood vessel problems? _____

Respiratory: Please circle if applicable and rate the pain/occurrence from 1 to 10

Cough _____ Coughing blood _____ Asthma _____ Bronchitis _____ Pneumonia _____

Pain in deep breath _____ Difficulty in breathing when lying down _____ Production of phlegm _____

Any other lung problems? _____

Comments: (problems you would like to discuss)

_____

_____

_____

_____

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AcuWellness
Atlanta

Dear AcuWellness Atlanta Patient,

In order to serve you better, we have found it necessary to implement the following policies. Please read carefully each section below and initial in the space provided. Then, sign that you understand and agree. Thank you very much for your patronage. We truly appreciate you.

Yours in health & happiness,
Dr. Li Liu

___ Payment in full is due for services and products at the time of the appointment.

___ Pre-Paid Packages are non-transferable and may not be combined with any other special offers.

___ A fee of $25 will be assessed for appointments that are canceled less than 24 hours ahead of time or if you fail appear for the appointment. Please know that an appointment is honored by Dr. Li Liu as a specific time scheduled for you. Others may be turned away in respect for that time.

(In light of unforeseen incidences causing delay, please kindly call the office to let us know your anticipated time of arrival.)

___ Supplements may be returned for clinic credit within 2 weeks after purchase if they are not expired and unopened.

I have read, understand and agree with the above policies.

Patient Signature *Date*

Printed Name

SYMPTOM SURVEY FORM-Acupuncture

Patient: _____ Date: _____

Birth Date: _____ Age: _____ Male □ Female □ Vegetarian: Yes □ No □

INSTRUCTIONS: Fill in only the circles which apply to you.

- ● o o MILD symptoms (occurred once or twice in the last 6 months)
- o ● o MODERATE symptoms (occurred once or twice in the last month)
- o o ● SEVERE symptoms (chronic, occurred once or twice in the last week).
- o o o **Leave circles BLANK if they don't apply to you.**

1 2 3	Group 1
o o o	Allergies
o o o	Arm/Wrist/Elbow Pain
o o o	Asthma/Bronchitis
o o o	Consipation
o o o	Cough/sneeze/phlegm
o o o	Eczema/psoriasis/rash
o o o	Flatulence
o o o	Frequent colds
o o o	Frontal/sinus Headache
o o o	Grief/sadness
o o o	Lethargy/fatigue
o o o	Loose Stools
o o o	Mucus
o o o	Nasal problem
o o o	Shoulder pain
o o o	Sinusitis
o o o	Smell problems
o o o	Stiff joints/neck
o o o	Sweating Problems
o o o	Weak voice
o o o	Wheezing/shortness of Breath

1 2 3	Group 2
o o o	Adrenal Weakness
o o o	Back/hip/knee pain
o o o	Bladder infec/control
o o o	Brittle bones
o o o	Cold hands/feet
o o o	Dark/puffy around eyes
o o o	Depression/fear
o o o	Edema/water retention
o o o	Hot Flashes
o o o	Impotence/libido
o o o	Infertility/sterility
o o o	Lethargy/fatigue
o o o	Loss/thinning hair
o o o	Night sweats
o o o	Poor memory
o o o	Premature gray
o o o	Sciatica/back pain
o o o	Sore throat in a.m.
o o o	Anger/irritability

1 2 3	Group 2
o o o	Tight hamstrings
o o o	Tinnitus
o o o	Urine problems

1 2 3	Group 3
o o o	Bruising
o o o	Depression
o o o	Distention/bloating
o o o	Eye/vision problems
o o o	Flatulence
o o o	Headaches
o o o	Hemorrhoids
o o o	Indigestion
o o o	Irritable bowel
o o o	IT Band tightness-thigh/buttocks
o o o	Lack of flexibility
o o o	Menstrual irregularity
o o o	Migraines
o o o	Nausea/vomitting
o o o	PMS
o o o	Stiff neck/shoulders
o o o	Tension/cramps
o o o	Tinnitus

1 2 3	Group 4
o o o	Abdominal Pain
o o o	Anemia
o o o	Anxiety/dread
o o o	Digestive troubles
o o o	Dream disturbed sleep
o o o	Elbow/shoulder pain
o o o	Hearing problems
o o o	Heart problems
o o o	Hot flashes
o o o	Hot/painful joints
o o o	Lack of joy/humor
o o o	Mouth sores
o o o	Neck pain
o o o	Palpitations
o o o	Poor circulation
o o o	Restlessness
o o o	Sleep problems

1 2 3	Group 4
o o o	Urine problems
o o o	Wrist pain

1 2 3	Group 5
o o o	Abdominal pain
o o o	Aching/heavy limbs
o o o	Anemia
o o o	Appetite/digestive problems
o o o	Belching
o o o	Bruise easily
o o o	Colic/indigestion
o o o	Difficulty focusing
o o o	Distention/bloating
o o o	Headaches
o o o	Heaviness at head
o o o	Hemorrhoids
o o o	Hiccups
o o o	Irritable bowel
o o o	Lethargy fatigue
o o o	Loose stools
o o o	Muscle weakness
o o o	Nausea/vomiting
o o o	Poor memory
o o o	Prolapse
o o o	Worry/overthinking

List 5 main complaints in order of importance

1. _____
2. _____
3. _____
4. _____
5. _____

For office use only

Sympton Score _____ Date: _____
# of ACU Visits _____
% Improvement _____

EMI results:
# of imbalanced Meridians: ____
Baseline change: _____
% Improvement: _____

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