INTEGRATIVE HEALTH

Acupuncture & Herbal Medicine

This is a confidential questionnaire to help us determine the best treatment for you. If you have any questions please ask. Thank you.

I. General Patient Information

Patient Name_____Date_____

Date of Birth_____Age_____Sex_____Height_____Weight_____

Address_____

City_____State_____Zip_____

Home Phone _____ ☐ Work Phone _____ ☐

Cell Phone _____ ☐ Email Address _____ ☐

Please check which phone number/email you would like to be contacted

What is your occupation _____ Marital Status _____

Insurance_____ Name of Insured_____

Date of Birth of Insured_____

Emergency Contact Person _____ Phone _____

Current Primary Care Physician _____ Phone _____

Do you smoke cigarettes? Yes ☐ No ☐ How many per day?_____ How many years?_____

Do you currently have a pace maker? Yes ☐ No ☐

Do you currently take blood thinner medications such as Coumadin/Warfarin? Yes ☐ No ☐

Are you diagnosed with hemophilia? Yes☐ No☐

Have you had acupuncture/herbs before? Yes☐ No☐

What are the health problems for which you are seeking treatment?

_____

_____

_____

Please list any allergies &/or food sensitivities you may have.

_____

_____

Please list any surgeries you've had in the past?

_____

_____

II. Past Medical History & Medication

Please list any medical conditions that you were diagnosed by a medical physician and current medication(s)

Condition	Date diagnosed	Medication & dosage/day

III. General Symptoms

Please check the symptoms that you experience frequently (once a week or more)

☐ Lack of appetite	☐ Easily angered	☐ Skin problems	☐ Lower back pain
☐ Excessive appetite	☐ Restlessness	☐ Varicose veins	☐ Knee problems
☐ Insomnia	☐ Chest pain	☐ Edema	☐ Easily bruised
☐ Heart palpitations	☐ Fatigue	☐ Colds hands/feet	☐ Soft/brittle nails
☐ Anxiety	☐ Sciatic pain	☐ Numbness	☐ Sudden weight loss/gain
☐ Night sweats	☐ Sweat easily	☐ Bruise easily	☐ Sensitivity to wind

IV. Ears, Eyes, Nose and Throat

Please check the symptoms that you experience frequently

☐ Frequent colds	☐ Shortness of breath	☐ Blurry vision	☐ Frequent headaches
☐ Chronic runny nose	☐ Bleeding gums	☐ Red/dry eyes	☐ Dizziness
☐ Sore throat	☐ Bleeding nose	☐ Excessive tearing	☐ Nasal congestion
☐ Chronic cough	☐ Sores in mouth	☐ Spots in field of vision	
☐ Coughing blood	☐ Excessive dry mouth	☐ Ringing in ears	
☐ Coughing mucous	☐ Excessive thirst	☐ Popping of ears	

List other symptoms not listed:_____

V. Digestive

Please check the symptoms that you experience frequently (more than once a week)

☐ Belching	☐ Nausea	☐ Heartburn	☐ Indigestion
☐ Acid regurgitation	☐ Stomach pain	☐ Vomiting	☐ Ulcers
☐ Bloating	☐ Epigastric discomfort	☐ Hypochondriac pain	

List other symptoms not listed above:_____

VI. Excretory

Please check the symptoms that you experience frequently

☐ Constipation	☐ Diarrhea	☐ Undigested foods in stool	☐ Bloody stools
☐ Hemorrhoids	☐ Gas	☐ Incontinence	☐ Dribbling urine
☐ UTI	☐ Frequent urination	☐ Blood in urine	☐ Night urination
☐ Burning sensation while urinating	☐ Leukorrhea		

List other symptoms not listed above: _____

VII. Female Patients

Gynecological History

*Please fill out Section **A** or Section **B***

A.** Please fill out this section if you are **pre menopausal:

Are you currently pregnant? Yes ☐ No ☐

Are you currently taking contraceptives? Yes ☐ No ☐

If yes:

Reason_____

From what age_____

Type_____

Product name_____

Do you use pads or tampons? *Circle one.*

What is the brand name?_____

What age did you start menstruating?_____

Are your cycles regular? Yes ☐ No ☐

Number of days between cycles_____ Number of days of flow_____

Number of days heavy_____ Number of days light_____

Are there clots in the flow? Yes ☐ No ☐

If yes, size (penny, quarter) and on what days do they appear?_____

Do you bleed between cycles? Yes ☐ No ☐

Do you suffer from any pain before, during or after cycle? Yes ☐ No ☐

If yes, please describe location of pain and what days it occurs_____

_____

Do you suffer from PMS? Yes ☐ No☐

If yes, what are the symptoms and when do they occur during your cycle?

_____

_____

List any conditions diagnosed by your gynecologist:

_____

B. *Please fill out this section if you are* ***post-menopausal****:*

What age did you start menstruating?_____ What age did you experience menopause?_____

Are you currently taking hormone replacement therapy? Yes ☐ No ☐

Please check the symptoms that you experience frequently (more than once a week)

☐ Vaginal dryness	☐ Excessive dry skin	☐ Mood swings
☐ Decreased libido	☐ Loss of hair	
☐ Sweating: morning_____noon_____ night____		

VIII. Male Patients

Please check items that you experience more than once a week

☐ Decreased libido	☐ Premature ejaculation	☐ Impotence
☐ Erectile dysfunction	☐ Pain in testicles	☐ Dribbling urine
☐ Hair loss	☐ Delayed urine stream	☐ Burning pain while urinating

Please list other information not included in above:

_____

_____

_____

_____

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Scheduling an Appointment:

Please call to schedule an appointment with us. We spend at least 1-2 hours with new patients and 30-40 minutes with return patients.

Once you've scheduled an appointment make every effort to be on time. If you are running late, call the office and let us know.

Treatment Fees:

Initial Consultation/Treatment: *Fee: $145.00*

The initial consultation includes an in depth questionnaire which you can easily download from our website www.InTheAcu.com and conveniently fill out before your visit. An Acupuncturist will conduct a thorough evaluation and a complete health history. Then a unique treatment plan will address the patient's individual concerns.

Follow-up Treatment: *Fee: $105.00*

The treatment plan from the initial consultation will be continued.

Payment:

Payment is expected at the time of treatment and we accept credit, cash or check. There will be a charge of $35.00 for any returned checks. We do accept insurance, however, we suggest you call your carrier before your initial visit and ask if your policy includes acupuncture benefits.

Cancellations:

A 24 hour advanced notice is requested for any cancellation of appointments.
The patient will be responsible for payment in full of the missed appointment.