**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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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