ACUPUNCTURE & WELLNESS CENTER

Yevgeniya Libkhen, MS, CNS, LDN, CIMHP
email: jennylibkhenawc@gmail.com phone: (781) 474-2879

Today's date_____

CONTACT INFO

Full name_____

Preferred name: _____ Preferred pronoun: _____

Address_____

Tel. # _____ Alt. tel. #_____

Email_____ (for contact purposes only; not for sale/advertisement/distribution)

Ref. by _____

STATS AND VITALS

Age____ Date of birth_____ Sex assigned at birth _____ Ethnicity_____

Occupation_____ Marital status_____ No. of children _____

Height_____ Weight_____

Blood pressure_____/_____ Fasting blood sugar_____

Total cholesterol_____ HDL_____ LDL_____ Triglycerides_____

Disclaimer: This form is not intended to diagnose or treat anything. For informational purposes only.

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MEDICAL HISTORY

COMMON CONDITIONS	SELF	FAMILY	DESCRIBE
ADD/ADHD			
Alzheimer's Disease			
Autoimmune Conditions (specify)			
Birth Defects			
Bleeding Problem			
Cancer			
Depression			
Diabetes, Type 1 (childhood onset)			
Diabetes, Type 2 (adult onset)			
Digestive issues (specify)			
Epilepsy (seizures)			
Glaucoma			
Hearing Problems			
Heart Disease (Coronary Artery or Heart Attack)			
High Cholesterol (Hyperlipidemia)			
High Blood Pressure (Hypertension)			
Kidney Diseases			
Migraines, Headaches			
Miscarriage			
Osteoarthritis			
Stroke			
Thyroid Disorders			

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Other conditions not listed above and history of any surgical/hormonal/immunological treatments, procedures, and/or hospitalizations:

_____

_____

_____

List any past or present significant life events and/or trauma: _____

_____

_____

List any known allergies/sensitivities/intolerances, their triggers (foods/medications/environmental causes), and describe the reactions

ALLERGIC TO	REACTION	SEVERITY

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MEDICATIONS AND SUPPLEMENTS

List any medications (prescription and OTC) you are currently taking or took in the past year and reasons for taking them.

MEDICATION	REASON FOR TAKING AND WHO PRESCRIBED IT	WHEN DID YOU START/END?

List any supplements you are currently taking, brand of supplements, and dosage

SUPPLEMENT	DOSE	WHEN DID YOU START?

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HEALTH AND WELLNESS HISTORY

Do you currently smoke? **Y / N**

IF YOU ANSWERED "YES"	IF YOU ANSWERED "NO"
Since when?	Have you ever smoked? Y / N
How many packs/day?	If you answered "YES" to the above question, please, fill out column on the left.
Would you like to quit? Y / N	When did you quit?
Have you tried quitting? Y / N	
If you answered "YES" to the above questions, please, describe.	Please, describe how you were able to quit.

Do you consume alcohol? **Y / N** If so, how many drinks/week _____

Comments: _____

_____

_____

Do you consume marijuana/cannabis or any other controlled substance? **Y / N**

If so, please, provide more information: _____

_____

_____

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Describe your caffeine consumption

○ I do not consume caffeinated foods and/or beverages					
TYPE	**COFFEE**	**TEA**	**SODA**	**CHOCOLATE**	**ENERGY BOOSTERS**
AMOUNT (daily or weekly)					
ARE YOU ADDICTED?	Y / N	Y / N	Y / N	Y / N	Y / N

How many cups of non-caffeinated beverages do you drink daily, what kind?

Plain water _____ Flavored water ____ Juice _____ Soda _____ Diet soda ____ Herbal tea _____

Do you consume artificial sweeteners/sugar substitutes? **Y/N** If so, please describe the type and reason for consumption?

_____

_____

_____

Indicate and describe your physical activity

○ Sedentary lifestyle (no exercise)		
FREQUENCY	**TYPE OF ACTIVITY**	**DURATION**
○ 1-2 x / wk		
○ 3-4 x /wk		
○ 5+ x / wk		

Are you currently on a diet? Are there foods you intentionally avoid or include? How is your relationship with food? Please, describe

_____

_____

_____

_____

_____

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Please, describe your bowel habits.

How many times do you have a bowel movement? _____ per day/week/month (circle the applicable)

Please, refer to the Bristol Stool Chart (BSC) below to answer the following question.

What is the most frequent consistency of your stools? (indicate BSC type)

Do you ever experience stools that are black, green, pale (whitish or yellowing)? If so, please, comment: _____

_____

_____

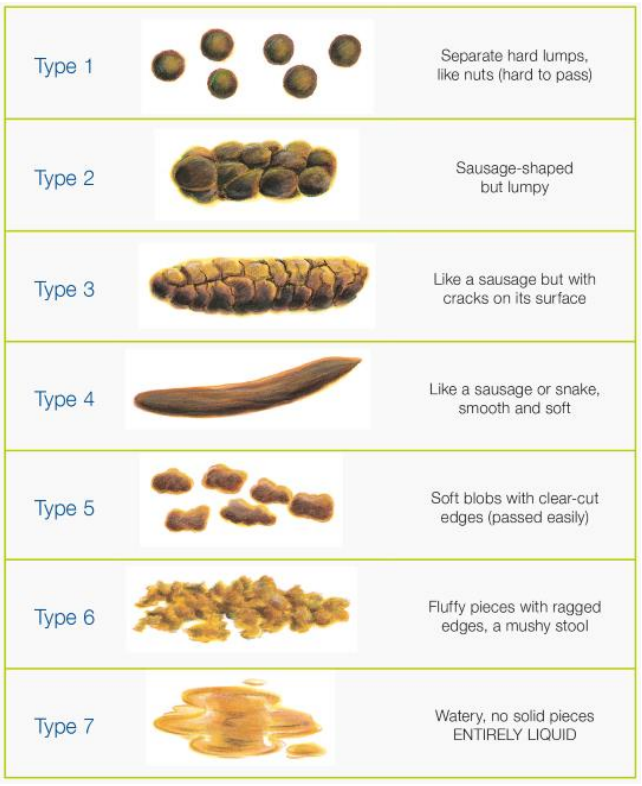
Do your stools sink or float? (circle the applicable)

Do you ever experience anal pain/irritation/burning/itching/bleeding with bowel movements? If so, please, comment: _____

_____

_____

The Bristol Stool Chart



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How would you rate your stress level (on a scale of 1-10, 10 being the most stressed) _____?

What are the primary stressors in your life? _____

_____

How do you cope with your stress? _____

_____

_____

At what time do you go to sleep? _____ How many hours do you sleep per night? _____

Do you wake up in the middle of the night? **Y / N**

If so, how often and why? _____

_____

If you do wake up in the middle of the night, do you have feelings of impending doom/racing heart? **Y /N**

Are you rested and alert after a night's sleep? **Y / N**

Do you nap or have a need to nap during the day? **Y / N**

GOALS

List your health goals in order of importance

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