Dancing Qi Acupuncture Health Questionnaire

Thank you for taking the time to fill out this intake form. The information you provide on this form is **confidential. Please PRINT legibly.**

Today's Date ___/___/___ **How did you hear about us?** Sign Brochure Ad Referral

Name _____ Date of Birth ___/___/_____ Age:____ Male____ Female____

Mailing Address_____ City_____ State____ Zip_____

Tel: (home)_____(work)_____(cell) _____

Email _____ OK to receive email announcements: Yes No

Occupation_____

Emergency Contact Person _____ Relationship_____Tel:_____

Physician_____Physician's Tel: _____

Traditional Chinese Medicine is a comprehensive holistic medicine that takes into consideration many aspects of your health. The following information will help determine the best course of treatment.

Reason for your visit:_____

_____

How long have you had this condition?_____ Is it getting worse?_____

Have you consulted a physician for this problem? Y / N If yes, were you given a diagnosis?

_____

What other treatments have you received for this condition?

_____

Does it disrupt your work/sleep/hobbies/other?

_____

Are there additional concerns would you like to address with Oriental Medicine?

_____

_____

Have you experienced acupuncture before? No ❑ Yes ❑

Are you currently pregnant or trying to get pregnant? No ❑ Yes ❑

Do you, or have you had any of the following condition(s)? Check all that apply:

- ❑ AIDS/HIV
- ❑ Alcoholism/Drug Addiction/Substance Abuse
- ❑ Allergies – circle (food, latex, medications, seasonal)
- ❑ Asthma, Emphysema, COPD
- ❑ Birth Trauma/Congenital birth defect
- ❑ Cancer
- ❑ Diabetes / Hypoglycemia
- ❑ Depression
- ❑ Fibromyalgia/ Chronic Fatigue Syndrome
- ❑ Heart Disease / Hypertension / Pacemaker / Atrial Fib.
- ❑ Hepatitis A/B/C
- ❑ Joint Replacements
- ❑ Lyme's Disease/ Tick Fever
- ❑ Lymph Nodes removed
- ❑ Chronic digestive problems
- ❑ Auto-Immune Disease: specify _____
- ❑ Scarlet Fever/Rheumatic Fever/Mononucleosis/Strep
- ❑ Seizures or Stroke
- ❑ Tuberculosis
- ❑ Chronic Pain / Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Psychological or Emotional Disorder
- ❑ STD / Herpes
- ❑ Multiple Sclerosis
- ❑ Thyroid disorder
- ❑ Trauma / Abuse
- ❑ Post traumatic stress disorder
- ❑ Ulcers – Oral / Stomach
- ❑ Ulcerative Colitis / Irritable Bowel Syndrome / Crohn's Disease
- ❑ Fertility/Menstrual difficulties
- ❑ Organs Removed
- ❑ Other:_____

Are you currently being treated for any of the conditions you checked? _____

_____

_____

Which of the following is a part of your lifestyle?

❑ Alcohol	❑ Coffee	❑ Tea
❑ Nicotine	❑ Recreational Drug Use	❑ Excessive Sugar

❑ Exercise: What and how often?

_____

❑ Dietary Restrictions: What and for how long?

_____

Have you had any surgical procedures or major accidents or injuries?

What	*When*	*What*	*When*

Please give any pertinent information:

_____

_____

Please list any prescription medications and/or supplements that you are taking now.

Medication	***Reason***	***Year Started***	***Dosage***
Example: Lipitor	*High cholesterol*	*1999*	*10 mg once a day*

Please give any pertinent information:

_____

_____

Family History: Please list any past and present health conditions and overall health.

Mother's Health_____

_____

_____

Father's Health_____

_____

_____

Please check any of the following symptoms you have experienced within the past 2 months or have a general tendency for:

- ❑ Intolerance for heat / cold
- ❑ Aversion to wind
- ❑ Unusual sweating/or lack of...
- ❑ Fever
- ❑ Chills
- ❑ Sneezing
- ❑ Sore throat
- ❑ Fatigue
- ❑ Difficulty staying awake
- ❑ Tremors
- ❑ Vertigo / dizziness
- ❑ Recent weight loss / gain
- ❑ Cold hands and/or feet
- ❑ Weakness/heaviness in limbs
- ❑ Poor coordination
- ❑ Craving for hot or cold drinks
- ❑ Bleed or bruise easily
- ❑ Rashes/Hives
- ❑ Eczema/Psoriasis
- ❑ Ulcerations
- ❑ Acne
- ❑ Itching
- ❑ Loss of hair
- ❑ Chest pain
- ❑ Heart palpitations
- ❑ Irregular heart beat
- ❑ Fainting
- ❑ Swelling of face or hands
- ❑ Gout
- ❑ Water retention (edema)
- ❑ Upper body edema
- ❑ Lower body edema
- ❑ Difficulty breathing
- ❑ Asthma /wheezing/tight chest
- ❑ Cough – dry/phlegm
- ❑ Chest pain
- ❑ Pain under ribs
- ❑ Pain in abdomen
- ❑ Appetite increase/decrease
- ❑ Gas / bloating
- ❑ Belching
- ❑ Heartburn/ Acid reflux
- ❑ Mouth sores
- ❑ Peculiar taste in mouth
- ❑ Bad breath
- ❑ Nausea/Queasiness
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Loose stools
- ❑ Hemorrhoids
- ❑ Rectal pain
- ❑ Laxative use
- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Wake to urinate: #times ____
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Urine leakage/Incontinence
- ❑ Copious, pale urination
- ❑ Dark, concentrated urination
- ❑ Bedwetting
- ❑ High sex drive
- ❑ Low sex drive
- ❑ Restless sleep
- ❑ Night sweats
- ❑ Nightmares/Vivid dreaming
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Wake at specific time _____
- ❑ Tired at specific time _____
- ❑ Hot flashes
- ❑ Depression/Sadness
- ❑ Lethargy/Low energy
- ❑ Mania
- ❑ Anxiety
- ❑ Excessive worry
- ❑ Obsessive behavior
- ❑ Easily angered or frustrated
- ❑ Uncontrolled anger
- ❑ Irritability
- ❑ Easily stressed
- ❑ Poor memory
- ❑ Thoughts of suicide
- ❑ Easily frightened/Fear
- ❑ Eye pain/heaviness
- ❑ Visual disturbance
- ❑ Night blindness
- ❑ Dry eyes
- ❑ Red or itchy eyes
- ❑ Twitching eyelid
- ❑ Cataracts
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Deafness
- ❑ Earache
- ❑ Nose bleed
- ❑ Sinus problems
- ❑ Post nasal drip
- ❑ Dry throat
- ❑ Recurrent sore throat
- ❑ Swollen glands
- ❑ Frequent illness
- ❑ Thyroid disease
- ❑ Dry mouth
- ❑ Copious saliva
- ❑ Jaw pain/clicking
- ❑ Grinding teeth
- ❑ Facial pain
- ❑ Teeth / gum problems
- ❑ Headaches
- ❑ Migraines
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Limited range of motion
- ❑ Muscle twitching/spasm
- ❑ Substance abuse
- ❑ Alcoholism

Check all areas of pain-or-numbness. indicate which side(s) (R and/or L):

- ❑ Head - R/L
- ❑ Neck - R/L
- ❑ Shoulder - R/L
- ❑ Arm - R/L
- ❑ Elbow - R/L
- ❑ Wrist - R/L
- ❑ Hand - R/L
- ❑ Fingers - R/L
- ❑ Upper back - R/L
- ❑ Middle back - R/L
- ❑ Low back - R/L
- ❑ Hip - R/L
- ❑ Upper leg - R/L
- ❑ Knee - R/L
- ❑ Lower leg - R/L
- ❑ Ankle - R/L
- ❑ Heel - R/L
- ❑ Foot - R/L
- ❑ Toes - R/L
- ❑ All over body pain
- ❑ Pain worse with _____
- ❑ Pain better with _____
- ❑ Pain moves around
- ❑ Pain is in a fixed place

For men only:

- ❑ Impotence
- ❑ Enlarged prostate
- ❑ Premature ejaculation
- ❑ Nocturnal emission
- ❑ Other_____

For Women only:

- ❑ Irregular menstruation
- ❑ Pain with periods
- ❑ Breast pain or distention
- ❑ Vaginal discharge
- ❑ Spotting between periods
- ❑ Breast lumps
- ❑ Clots with periods
- ❑ # days between periods _____
- ❑ # days in flow _____
- ❑ Heavy flow
- ❑ Light flow
- ❑ Medium flow
- ❑ # of pregnancies _____
- ❑ # of births _____
- ❑ # of miscarriages _____
- ❑ Birth by c-section
- ❑ Date of last period _____
- ❑ Menopause: age_____
- ❑ Hysterectomy: age ____
- ❑ Ovarian cysts
- ❑ Endometriosis/ Fibroids
- ❑ Other: _____