Acupuncture Health History Questionnaire

Name: ______________________ Date: ______________

Address: ____

City: ______________ **State:** ______________ **Zip Code:** ______________

Phone: (H) ______________ (C) ______________ (W) ______________

E-Mail: ______________ **Emergency Contact:** ______________

Gender: ______________ **Date of Birth:** ______________ **Age:** ________ **Marital Status:** ________

Referred By: ______________________ **Family Physician:** ______________

Occupation: ______________ **Hobbies:** ______________________

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? ______________________

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Please describe your average daily diet: ____________________

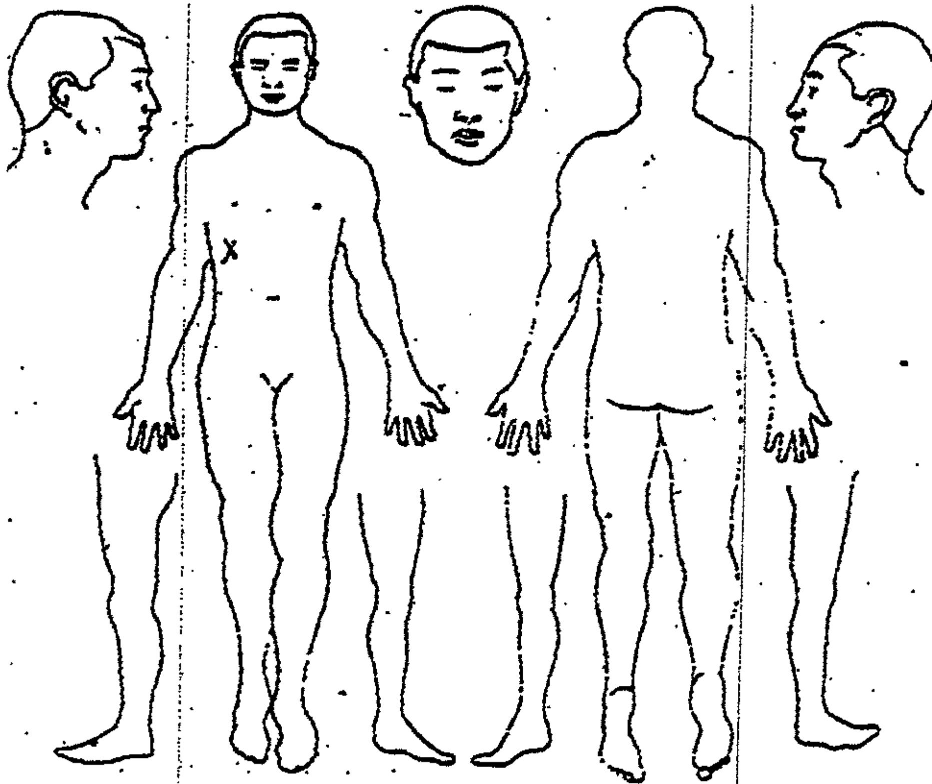
Do you smoke, how much? __________ Do you drink coffee/tea or cola and how much? ____________

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

Lack of coordination _____ Concussion _____ Depression _____ Anxiety _____ Bad Temper _____

Easily susceptible to stress _____ Have you ever been treated for emotional problems? _______________

Have you ever considered or attempted suicide? ____

Have you had neurological or psychological problems? ____

____

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

Poor appetite _____ Poor sleeping _____ Fatigue _____ Fevers _____ Chills _____ Night Sweats __

Sweat easily _____ Tremors _____ Cravings _____ Bleed/Bruise easily _____ Weight loss _____

Weight gain _____ Localized weakness _____ Change in appetite _____

Peculiar tastes or smells ______________________ Strong thirst (prefer hot or cold drinks) ______

Sudden energy drop (what time of day)? ____

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

Rashes _____ Ulcerations _____ Hives _____ Itching _____ Eczema _____ Pimples _____

Dandruff _____ Loss of hair _____ Recent moles _____ Change in hair or skin texture _____

Any other hair or skin problems? ____

Head, Eyes, Ears, Nose, and Throat: Please circle if applicable and rate the pain/occurrence from 1 to 10

Dizziness _____ Concussions _____ Migraines _____ Glasses _____ Eye strain _____ Eye pain ___

Poor vision _____ Night blindness _____ Color blindness _____ Cataracts _____ Blurry vision _____

Earaches _____ Poor hearing _____ Spots in front of eyes _____ Sinus problems _____

Nose bleeds _____ Recurrent sore throats _____ Grinding teeth _____ Facial pain _____ Jaw clicks _

Sores on lips or tongue _____ Teeth problems _____

Any other head or neck problems? ____

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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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____

____

____

WELCOME TO 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.

Sign that you understand and agree. Thank you for your patronage. We truly appreciate you.

Yours in Health & Happiness,

Dr. Li Liu, L.Ac.

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

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

______ A fee of $25 may be assessed for appointments that are canceled less than 24 hours ahead of your time to appear. Others may be turned away in respect for that specific time scheduled for you.

______ In light of unforeseen incidences causing delay, please call our office to let us know your anticipated time of arrival.

______ ONLY the patient is allowed in the therapy room session. (Unless approved by Dr. Liu)

______ Questions regarding patient accounts MUST be directed to an Office Administrator during office hours.

______ All sales are final, NO product or service package returns.

______ We do not file insurance as we are a fee for service out of network clinic. We can give you a Superbill to file with your insurance company if they cover acupuncture.

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

*Signature:*______________________________ *Date:*__________________

*Print Name:*______________________________