sahm ACUPUNCTURE HEAVEN | EARTH | HUMANITY

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

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Email_____

Cell Phone _____ Occupation _____

Emergency Contact : Name _____ Phone _____

Who should we thank for referring you to this office? _____

Sex : ☐ Male ☐ Female ☐ Other_____ Height _____ Weight _____ Birth date _____ Age ____

Marital Status : ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Significant other

Have you received acupuncture therapy before? ☐ Yes ☐ No

When? _____ With whom? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☒	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Genetic/ Metabolic Disorders	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Diseases	☐	☐	_____	Other*_____	☐	☐	_____

List any medications and supplements you are currently taking: (Continue on last page, if necessary.)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Supplements	Dosage	Reason	How long	Prescribed by	Date of last checkup

Check the Box if any of the following statements are true:

☐ I have known allergies ☐ I am taking Coumadin/warfarin

☐ I have a pacemaker ☐ I am taking lithium ☐ I am taking _____

Diet/ Digestion: ☐ Omnivore ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Other:_____

☐ Indigestion: ☐ Often ☐ Occasionally ☐ Seldom ☐ "Sour Stomach" ☐ Gnawing Hunger ☐ Acid Reflux ☐ GERD ☐ History of Ulcers

☐ Bloating: ☐ Above ☐ Below Abdomen ☐ Whole Abdomen ☐ Distention ☐ Belching

☐ Nausea: ☐ Morning ☐ All day ☐ Intermittent ☐ Around meals ☐ Night time ☐ Car sick ☐ Vomit

☐ Difficulty digesting: ☐ Dairy ☐ Oily foods ☐ Raw Foods. ☐ Alcohol. ☐ Carbohydrates ☐ Sugar

Any allergies, food sensitivities or food cravings/restrictions that you have:

_____

Please indicate the use and frequency of the following:

	Y	N	How much		Y	N	How much		Y	N	How much
Coffee/black tea	☐	☐	_____	Tabacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda	☐	☐	_____

How do you FEEL about the following areas of your life?:

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad
Significant other	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐
Diet	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Self/Self image	☐	☐	☐	☐	☐
Work	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐
Spirituality	☐	☐	☐	☐	☐
Emotions	☐	☐	☐	☐	☐
LifeStyle	☐	☐	☐	☐	☐

Your comments

What is your average stress level? (1 is lowest, 10 highest) _____

What is your average energy level? (1 is lowest, 10 highest) _____

What time of the day is your energy typically at it's best? _____ it's worst?_____

Sleep: #____hrs a night ☐ Difficulty Falling asleep ☐ Difficulty Staying asleep ☐ Wakes often ___X @ ___:_____am / pm

☐Stays awake "thinking" ☐ Insomnia ☐ Somnolence ☐ Vivid Dreams/ / Nightmares ☐ Restless sleep ☐ Restless Leg Syndrome

☐ Snores / Apnea ☐ Wakes Unrefreshed ☐ Other:

Elimination: ☐ Urination Difficulties. ☐ Bowel Movement Difficulties

Urine: ☐ Pain/Strain. ☐ Urgenc /Frequency ☐ Burning ☐ Incomplete/Retention ☐ Difficult /Start/ Stop ☐ Incontinent / Leaks

☐ Night time ____X ☐ Other:

BM: ___ X a day ☐ Regular ☐ Irregular ☐ Complete- satisfied ☐ Incomplete- unsatisfied ☐ IBS -Constipation ☐ IBS -Diarrhea

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Other Disease. ☐ Pain ☐ Other:

Symptom Survey

The following is a list of symptoms that you CURRENTLY may experience. Check mark (√) = sometimes experience

__ Lack of appetite	__ Insomnia	__ Chest oppression	__ Cough
__ Excessive appetite	__ Difficulty falling asleep	__ Abdominal pain	__ Shortness of breath
__ Loose stool or diarrhea	__ Difficulty staying asleep	__ Sciatic pain	__ Decreased sense of smell
__ Digestive problems	__ Nightmares/vivid dreams	__ Neck pain	__ Nasal/Sinus problems
__ Indigestion	__ Somnolence	__ Shoulder pain	__ Skin problems
__ Vomiting	__ Heart palpitations	__ Wrist/carpel pain	__ Bronchitis
__ Belching/Burping	__ Angina/ Chest pains	__ Other pain:	__ Feeling of claustrophobia
__ Heartburn/Reflux	__ Mentally restless	__ Headaches	__ Night sweats
__ Feeling of retention of food	__ Periods of hyperactivity	__ Migraines	__ Colitis/Diverticulitis
__ Constipation	__ Depression	__ Cold hands & feet	__ Hemorrhoids
__ Gas/Bloating	__ Anxiety	__ Cold in genital area	__ Recent use of antibiotics

__ Eye problems	__ Lower Back Pain	__ Black Tarry stools	__ Dissatisfaction
__ Floaters in eyes	__ Knee problems	__ Easily bruised	__ Loneliness/grief
__ Jaundice	__ Hearing impairments	__ Difficulty stopping bleeding	__ Weepiness
__ Difficulty digesting oily foods	__ Ear ringing	__ Tendency to catch colds easily	__ Disconnected
__ Gallstones	__ Kidney stones	__ Intolerance to weather changes	__ Frustration
__ Light colored stools	__ Decreased sex drive	__ Allergies	__ Giddiness
__ Soft or brittle nails	__ Increased sex drive	__ Hay fever	__ Nervousness
__ feeling of something "stuck" in throat	__ Hair loss	__ Dizziness/Vertigo	__ Obsessive: about what?
__ Frequent sighing	__ Fatigue/exhaustion	__ Tendency to faint	__ Indecisiveness
__ Spasms or twitching of muscles	__ Edema	__ Sudden weight loss	__ Fearful
	__ Blood in stools	__ Unusual weight gain	__ Anger or Agitation

In the space provided below, please feel free to write down any other signs or symptoms and any other information you would like to mention that have not been covered in the previous pages

What are the main health problems for which your are seeking treatment? Please list in order of importance.

1._____ Date of onset: _____
2._____ Date of onset: _____
3._____ Date of onset: _____
4._____ Date of onset: _____

Please indicate any other important information: Lab/ MRI results: please submit copies if necessary.

_____

List any accidents, surgeries, or hospitalizations: (include dates)

_____

What other forms of treatment have you sought?

Are you under a physician's care for any of your health concerns? (please describe if appropriate):

Please name your Physician and his/her contact information:

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No #of pregnancies_____

Age of last period (menopause) _____ # of live births ___ # of Abortions ___ # of Miscarriages ____

Date of last: Gynecologic exam _____ Pap Smear ☐ Yes ☐ No Results:_____

Mammogram ☐ Yes ☐ No Bone Density Scan ☐ Yes ☐ No Results:_____

# of days between periods _____ # of days of flow _____ Midcycle Bleeding? ☐ Yes ☐ No

Color of menstrual Blood: ☐Pale/light red ☐dark red ☐Red ☐dark red/brown ☐Bright red ☐clots

Amount of menstrual Blood: ☐Light ☐Heavy ☐Even throughout ☐Starts /stops ☐Spotting

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID

☐ ☐ Beast/Uterine/Ovarian Cancer ☐ Other _____

Location of Menstrual Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other:_____

Do you experience symptoms related to pelvic floor, menstrual and sexual health:

☐ Menstrual Cramps	☐ Pain of Vulva	☐ Bloating	☐ Retention of urine	☐ Increased Libido
☐ Back Pain	☐ Pain with penetration	☐ PMDD	☐ Bladder Pain	☐ Decreased Libido
☐ Hip/ groin pain	☐ Vaginal dryness	☐ Fibroids	☐ IBS-Constipation	☐ Breast cancer
☐ Swollen breasts	☐ Vaginal discharge	☐ Endometriosis	☐ IBS-Diarrhea	☐ Uterine cancer
☐ Fibrocystic breasts	☐ Vaginal Odor/BV	☐ Ovarian cysts	☐ IBS-Alternating	☐ Ovarian cancer
☐ Mood swings	☐ Inability to orgasm	☐ PCOS	☐ Rectal dysfunction	☐ Other cancer
☐ Headache/Migraine	☐ Pain with orgasm	☐ Prolapse	☐ Hemorroids	☐ Fibromyalgia
☐ Insomnia	☐ Yeast infections	☐ UTI	☐ Anal Fissures	☐ Chronic fatigue
☐ Hot flashes	☐ Itching of genitalia	☐ Incontinence	☐ PID	☐ SI joint/Coccyx pain
☐ Night sweats	☐ Burning of genitalia	☐Urgency/Frequency	☐ Hysterectomy	☐ Pudental nerve pain

How long? _____. What other forms of birth control have you used in the past? _____

Sexually Transmitted Diseases: ☐Gonorrhea ☐Syphilis ☐AIDS ☐HPV ☐Chlamydia ☐Herpes For how many years? _____

Is your Fertility an issue? What (if any) treatments have you sought for fertility?

Do you experience any other sexual difficulties? (please describe)

Thank you for taking the time to answer these questions, we appreciate your time & efforts.

_____ _____

Patient eSignature* Date

***By typing in my name, above I certify that the information I have provided is correct and accurate to the best of my knowledge and I consent to use it in place of a hand written signature.**