Initial Health Evaluation Questionnaire

Updated Jan 2017

Please help me provide your evaluation by filling out this form carefully. This form will save time in the initial interview process. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you.

Today's Date	Who Referred You		
Name		Age	Date of Birth
Address			
City State Zip		Marital status	
Home ph	Work ph	Cell ph	
Occupation	In emergency notify	at phone:	
Your Physician:	Chiropractor:		
Specialist:	Massage therapist:		
Prior Acupuncture/dates	Acupuncturist:		

EMAIL ADDRESS:_____

If prior acupuncture, for what and was it helpful?_____

Problems you are experiencing today you'd like help with

_____

_____

_____

How long have you had them_____

Circumstances at the onset of these symptoms _____

_____

Other therapies have you tried for this problem _____

_____

Date of last medical check-up for this problem:_____Practitioner: _____

Your medical diagnosis _____

Significant medical history: Surgeries, Accidents, Hospitalizations _____

_____

_____

Appendicitis/Appendectomy _____Tailbone or coccyx injury_____Abdominal Surgery_____

Allergies _____

Personal History of: Diabetes Cancer Hep A Hep B Hep C HIV Seizures Rheumatic Fever Thyroid Disease Pacemaker Heart Disease Stroke High Blood Pressure Atherosclerosis Tuberculosis Obesity Candidiasis Fibromyalgia Chronic Fatigue Syndrome Lupus Herpes Strep Staph Epstein Barr Virus Cold Sores Chicken pox Shingles Genital herpes Venereal Disease Mononucleosis Measles (rubella) Mumps Whooping Cough Parasites Worms Other Infections: _____

Have you traveled overseas Yes ___ No ___ Are you **LEFT-Handed**?_____
Current Medicines and Supplements with amounts and frequency_____

_____

_____

_____

_____

_____

Herbs you take presently - Describe form and amounts_____

_____

_____

_____

Describe exercise program and activity level_____

_____

Environmental Exposures you are concerned about_____
Smoking amount _____Stopped When?_____
Amount of Alcohol consumed per week_____
Amount of coffee or tea per day_____
Describe your average daily diet Vegetarian/Vegan
Breakfast_____
Lunch_____
Dinner_____
Snack_____
Are you environmentally or chemically sensitive? Yes ___ No ___
If 'Yes' to what things_____
Do you consider youself to be able to handle stressful situations? Yes ___ No ___
If 'No' please explain _____
Do you have a history of abuse or emotional or physical trauma? Yes ___ No ___
Vaccinations you have had:

_____

_____

_____

Birth Trauma or issues while you were in the womb:_____
Major Family Medical History_____

_____

_____

_____

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SYMPTOM CHECK LIST

Please **Circle** any problem or symptom that you have presently. <u>Underline</u> problems you had in the past.

SKIN eczema acne rashes dermatitis boils fungal problems warts hair loss fingernail problems

HEART AND VESSELS fast pulse (over 100) slow pulse (under 60) palpitations angina poor circulation irregular heartbeat pressure in your chest shortness of breath chest pain dizziness heart attack migraine with nausea cold hands or feet Raynaud's flushed face anemia hypertension or high blood pressure low blood pressure cold sweats dizzy when standing up quickly or when standing a long time

DIGESTIVE constipation diarrhea no appetite poor appetite stomach pain indigestion heartburn abdominal bloating belching ulcer gastritis poor stomach acid hemorrhoids GERD pancreatitis irritable bowel polyps tumors too much gas cancer

RESPIRATORY asthma bronchitis emphysema cough wheezing pneumonia lung disease

HORMONAL low thyroid hyperthyroid diabetes I or II low blood sugar fatigue weight gain

Women's health problems menstrual problems cramping heavy, light, irregular periods PMS emotional reactions menopause symptoms tubal ligation infertility low libido breast cancer hot flashes hysterectomy polycystic ovarian syndrome endometriosis fibroids other reproductive cancer ovarian cyst no periods

Men's health problems impotence premature ejaculation prostate problems vasectomy infertility testicular problems cancer frequent urination urgent urination incomplete urination difficulty beginning urine stream

EAR NOSE AND THROAT deafness tinnitus/ear ringing itchy ears ear pain ear infections sinus headaches chronic sinus infections yellow nasal discharge stuffy nose post nasal drip nasal allergies runny nose dry nose nosebleeds itchy throat strep throat sore throat

MOUTH bleeding gums periodontitis tooth abscess mumps sores in corners of mouth canker sores cold sores TMJ toothaches oral surgery false teeth bridges implants bad teeth restorations

GENERAL HEALTH insomnia exhaustion too sleepy emotional problems alcoholism addiction difficulty concentrating car sickness/motion sickness no appetite for breakfast bad mood in the mornings unusual sweating never sweat difficulty getting up in morning accident prone fatigue legs get tired Feel spacey scattered thinking too energetic late at night long shower or bath makes you feel weak get sick often apathetic angry mood irritable anxious depressed panic or panic attacks

INFLAMMATIONS AND AUTOIMMUNE Hashimoto's thyroid disease joint pain lupus rheumatoid arthritis colitis Crohn's disease baldness allergy food allergy scleroderma chemical sensitivity atopic dermatitis neurodermatitis cellulitis vasculitis vulvitis low immunity myofascial pain syndrome fibromyalgia kidney disease plantar fasciitis scarlet fever ear infections repeated strep infections staph infections swollen glands tendonitis pericarditis ulcerative colitis

MEDS birth control pill hormone replacement Prednisone chemotherapy Coumadin Narcotics

Other general information

Mood which seems to be most common for you_____

Mood which predominates when you are UNDER STRESS_____

What work-shift do you currently have: 1st ____ 2nd ____ 3rd ____ Hours per week_____

Season in which you feel best_____ worst_____

Weather which improves your condition_____worsens_____

Best temperature for you_____Worst temperature for you_____

I have seen or suspected a connection, correlation, or relationship between the following symptoms:

_____

_____

Something which I have wanted help with but have not been aided by my physician is:_____

_____

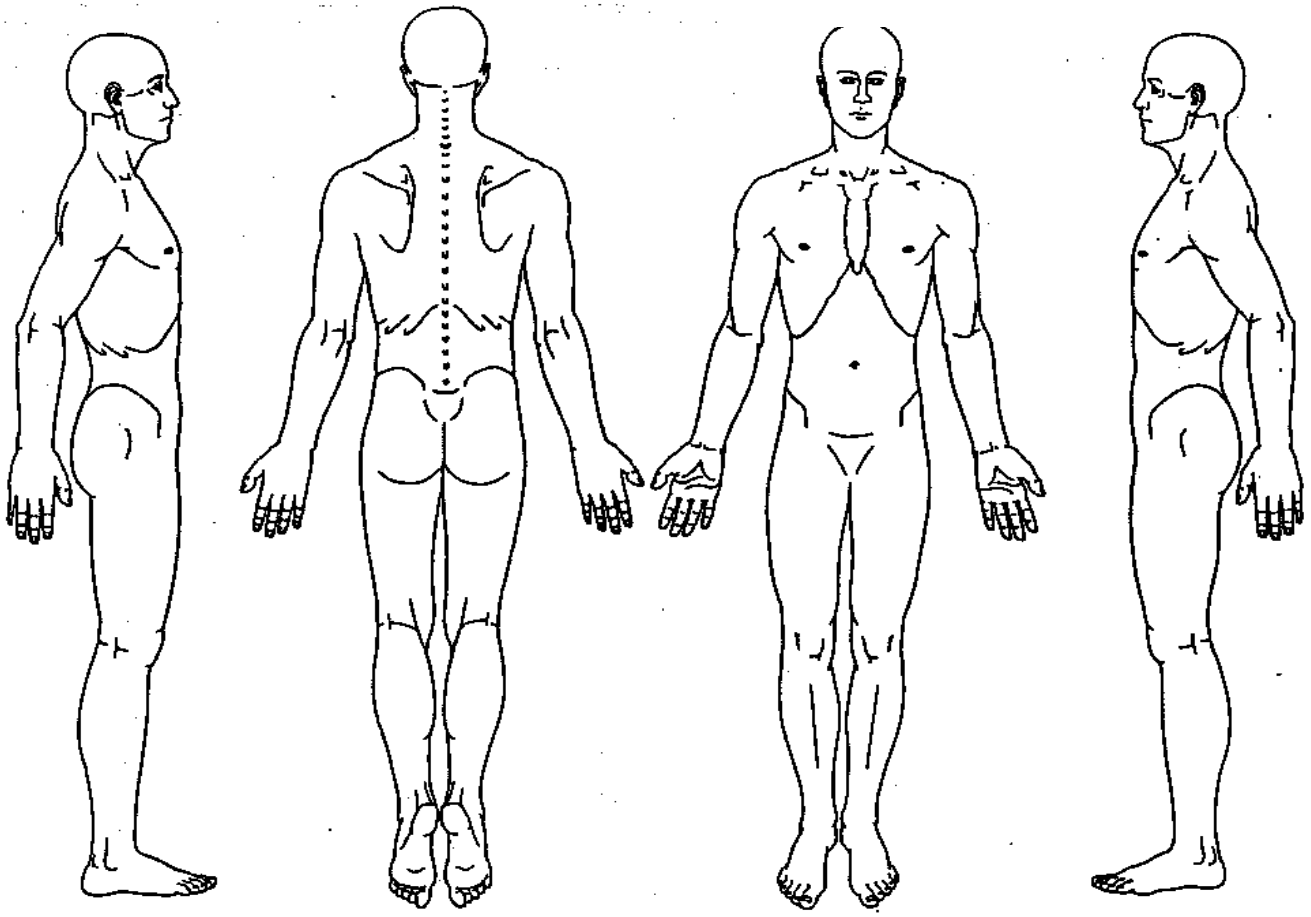
_____

Other Comments or things I'd like you to know_____

_____

_____

Please sketch any **pain** you have on the diagrams below



Acupuncture of Iowa, Inc. Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures for me (or the patient named below, for whom I am legally responsible) by the below-named licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Gua Sha, Chinese massage, Chinese herbal medicine, and dietary counseling and recommendations according to the principles of Chinese medicine.

The herbal and dietary supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately* by phone at her emergency number..

I have been informed that I have a right to refuse any form of treatment. I have read (or have had read to me) the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____ initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. A separate release will be obtained in order to contact the specific provider._____ initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation (except in case of emergency or extremely dangerous weather) _____ initials

_____ _____

Patient's name (print) Patient's signature

_____ _____

Patient's Representative & Relationship if applicable Date Signed

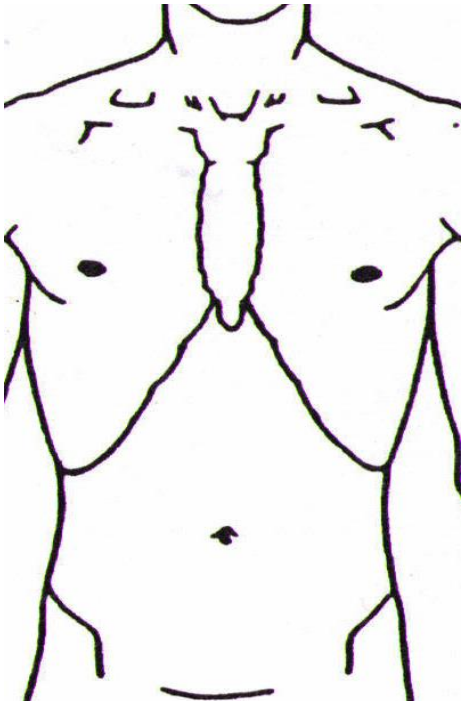
For the Acupuncturist: Pt understands PAR_____ agrees to treatment____ Date:

S:_____

O:_____

Resp:_____ Temp:_____ BP:_____Pulse Rate: _____

Abdomen:



Tongue:

Initial Assessment/Impressions:_____

Plan_____