

# 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 yourself 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 \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SYMPTOM CHECK LIST**

Please **Circle** any problem or symptom that you have presently. **Underline** 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: 1<sup>st</sup> \_\_\_\_ 2<sup>nd</sup> \_\_\_\_ 3<sup>rd</sup> \_\_\_\_ 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:

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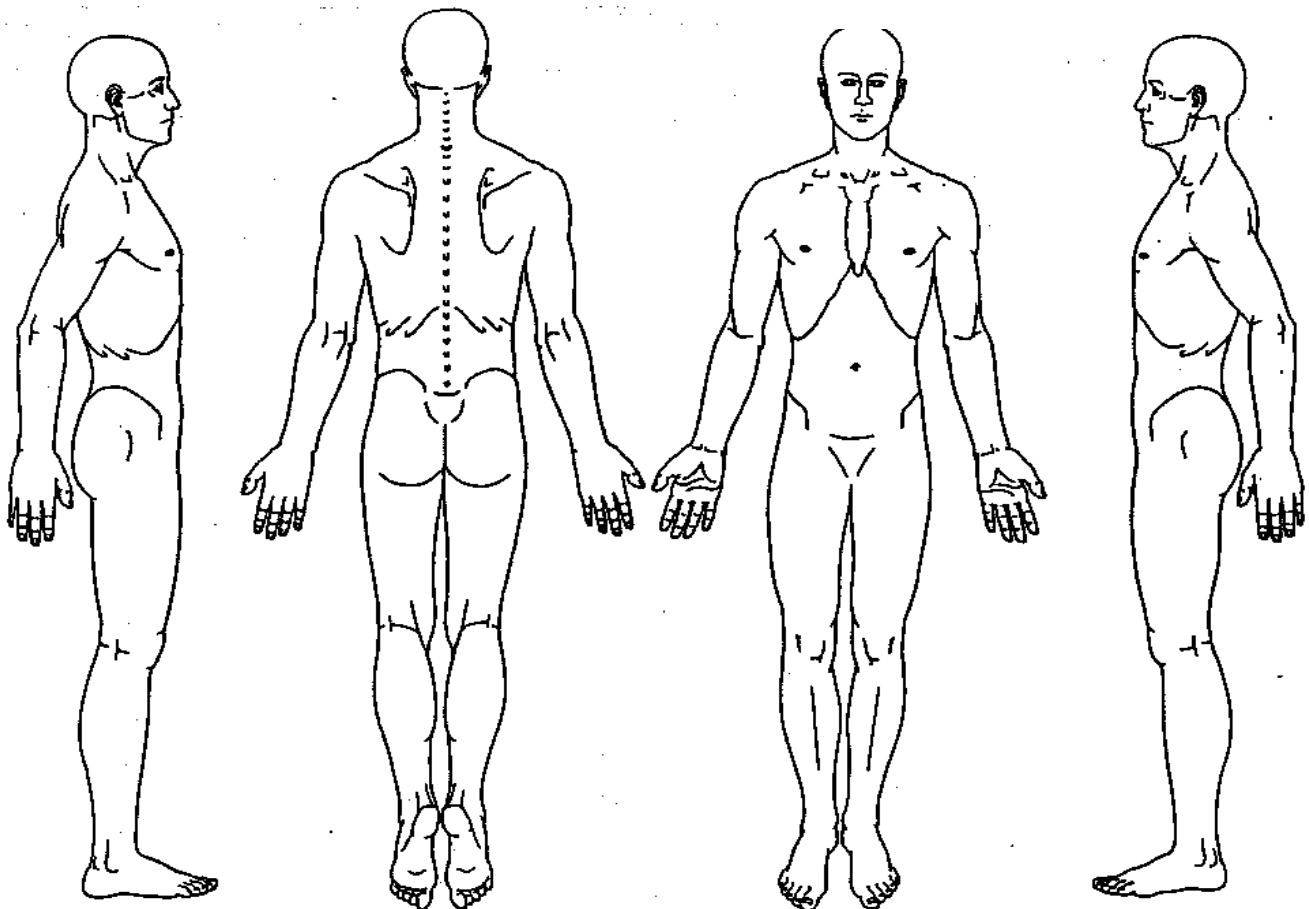
Something which I have wanted help with but have not been aided by my physician is: \_\_\_\_\_

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Other Comments or things I'd like you to know \_\_\_\_\_

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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

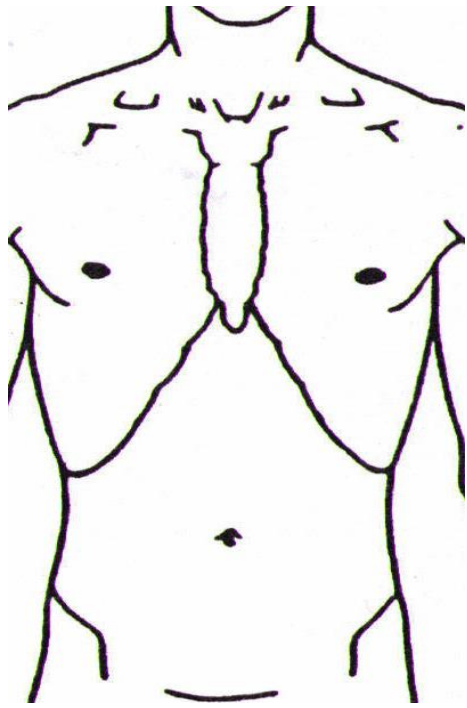
For the Acupuncturist: Pt understands PAR\_\_\_\_\_ agrees to treatment\_\_\_\_\_ Date:

S: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

O: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Resp:\_\_\_\_\_ Temp:\_\_\_\_\_ BP:\_\_\_\_\_ Pulse Rate: \_\_\_\_\_

Abdomen:



Tongue:

Initial Assessment/Impressions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan \_\_\_\_\_