Hayley Mermelstein, Acupuncturist

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefuIly. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it is the "Comments" section. Thank you.

Date ______________________

Name (First/Last) ______________________

Home Phone ____________ Work phone ____________ Cell phone ____________

Email ______________________

Street ______________________ City ____________ State/Zip ________

Date of Birth ____________ Age ______ Height ______ Weight ________

Have you been treated by acupuncture or Oriental medicine before? Yes No

Main problem(s) you would like us to help you with: ______________________

____

How long ago did this problem begin? Please be specific: ______________________

____

To what extent does This problem intefere sith your daily activities, such as work, sleep, and sex?

____

Have you been given a dagonises for this problem If so, what? ______________________

What kinds of treatment have you tried? ______________________

____

Past Medical History (please include date)

Significant Illnesses (*Please circle all applicable*)

Rheumatic Fever ____________ Venereal Disease ________ Cancer __________

High Blood Pressure __________ Heart Disease __________ Diabetes __________

Thyroid Disease ____________ Hepatitis ____________ Seizures __________

Other ______________________

Surgeries ______________________

____

Significan trauma (auto accidents, falls, etc.) ______________________

____

Allergies (drugs, chemicals, foods) ______________________

Family Medical History

Diabetes ________ Cancer ________ High Blood Pressure ________ Asthma ________

Stroke ________ Seizures ________ Heart Disease ____________ Allergies ________

Other ______________________

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): ______________________________

____

Occupational stress (chemical, physical, psychological, etc.): ______________________________

____

Do you have a regular exercise program? If *yes,* please describe: ______________________________

____

Have you ever been on a restricted diet? If yes, what kind? ______________________________

____

Please describe you average daily diet:

Morning	Afternoon	Evening

Do you smoke? If yes, how much? ______________________________

How much caffeinated coffee, tea or cola do you drink per week? ______________________________

____

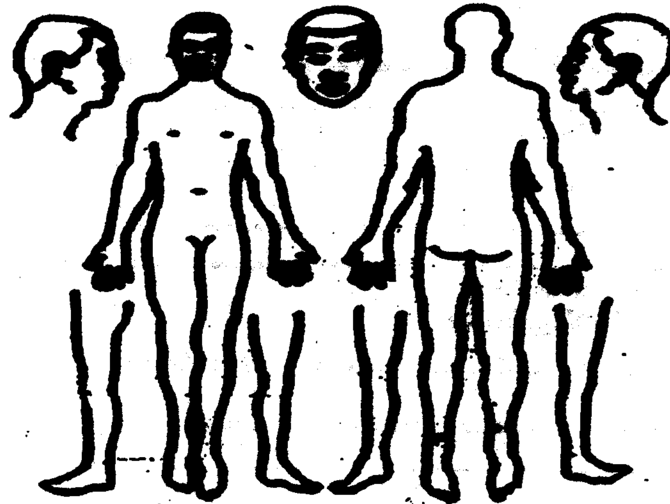
How much water do you drink per day? ______________________________

How much alcohol do you drink? ______________________________

Please describe any use of drugs for non-medical purposes: ______________________________

____

Indicate on the diagram below any painful or distressed areas:



Please check if you have had (in the last three months):

General

- ☐ Fevers
- ☐ Poor sleeping
- ☐ Fatigue
- ☐ Sweat easily
- ☐ Chills
- ☐ Night Sweats
- ☐ Bleed or bruise easily
- ☐ Weight loss
- ☐ Cravings
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (hot or cold drinks?)
- ☐ Change in appetite
- ☐ Sudden energy drop (what time of day?) ______________________________
- ☐ Weight gain

Patient Name ________________________________ **Date** ____________________

Skin & Hair

☐ 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

☐ Dizziness ☐ Concussions ☐ Migraines
☐ Glasses ☐ Eye strain ☐ Eye pain
☐ Poor vision ☐ Night blindness ☐ Color blindness
☐ Cataracts ☐ Blurry vision ☐ Earaches
☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of eyes
☐ Sinus problems ☐ Nose bleeds ☐ Recurrent sore throats
☐ Grinding teeth ☐ Facial pain ☐ Sores on lips or tongue
☐ Teeth problems ☐ Jaw clicks ☐ Headaches (where, when?)
☐ Any other head or neck problem? ____________________ ____________________

Cardiovascular

☐ High blood pressure ☐ Low blood Pressure ☐ Chest pain
☐ Irregular heart beat ☐ Difficulty in breathing ☐ Fainting
☐ Cold hands or feet ☐ Swelling of hands ☐ Swelling of feet
☐ Blood clots ☐ Phlebitis
☐ Any other heart or blood vessel problems? ________________________________

Respiratory

☐ Cough ☐ Coughing blood ☐ Asthma
☐ Bronchitis ☐ Pneumonia ☐ Pain with a deep breath
☐ Difficulty in breathing when lying down? ☐ Production of phlegm, What color? ____________
☐ Any other lung problems? ________________________________

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Gas ☐ Belching
☐ Black stools ☐ Blood in Stools ☐ Indigestion
☐ Bad breath ☐ Rectal pain ☐ Hemorrhoids
☐ Abdominal pain or cramps ☐ Chronic laxative use
☐ Any other problems with your stomach or intestine? ____________________________

Genito-Urinary

☐ Pain upon urination ☐ Frequent urination ☐ Blood in urine
☐ Urgency to urinate ☐ Unable to hold urine ☐ Kidney stones
☐ Decrease in flow ☐ Impotency ☐ Sores on genitals
☐ Do you wake up to urinate? Y/N How often? ___ ☐Any particular color to your urine ________
☐ Any other problems with your genital or urinary system? ________________________

Reproductive and Gynecologic

☐ Pregnancies? #:_____________ ☐ Live births? #:_____________ ☐ Miscarriages? #: _______
☐ Abortions? #: _____________ ☐ Premature births? #: ________ Age of first menses _______
Period of time between menses __________________ Duration of menses __________________
☐ Unusual character (heavy, light) ____
☐ Irregular Periods_____________ ☐ Painful periods _____________ ☐ Clots__________________
Date of last PAP _____________ ☐ Vaginal discharge___________ ☐ Vaginal sores ___________
☐ Breast lumps________________ ☐ Peri-menopause ___________ ☐ Menopause? Age_______
☐ Changes in body/psyche prior to menstruation ____________________________________
Do you practice birth control? Yes / No What type and for how long? _______________________

Musculoskeletal

☐ Neck pain ☐ Muscle pain ☐ Knee pain
☐ Back pain ☐ Muscle weakness ☐ Foot/ankle pains
☐ Hand/wrist pains ☐ Shoulder pain ☐ Hip pain
☐ Any other joint or bone problem? ____

Neuropsychological

☐ Seizures ☐ Dizziness ☐ Loss of Balance
☐ Areas of numbness ☐ Lack of coordination ☐ Poor memory
☐ Concussion ☐ Depression ☐ Anxiety
☐ Bad temper ☐ Easily susceptible to stress

Have you ever been treated for emotional problems? ____________________________________
____
____

Have you ever considered or attempted suicide? _______________________________________
____

Any other neurological or psychological problems? ____________________________________
____

Comments:

Please tell us of any other problems you would like to discuss.

____
____
____
____
____
____
____