Inner Harmony

Acupuncture and Oriental Medicine

Confidential Health Questionnaire

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Date:

Name				Home Phone	
Address				Cell Phone	
City		St	Zip		
Occupation				Work Phone	
Employer				Extension	
eMail Address					
Emergency Name				EM Phone	

Who can we thank for referring you?

Sex - M ☐ F ☐	Height:	Weight:	Age:	Birthday:
Marital Status - Married ☐ Single ☐ Divorced ☐ Widowed ☐			Children:	
Previous Acupuncture	Yes ☐ No ☐	When:	With Whom:	

General Health Questions

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food cravings that you have.

List any accidents, surgeries or hospitalizations & include dates

Inner Harmony Acupuncture & Oriental Medicine - Health Questionnaire

How do you FEEL about the following areas of your life? Please check the boxes 1 being the best you can possibly feel and 5 being the worst. Please then indicate any problems you may be experiencing in the space allowed to the right.

	1	2	3	4	5	Your Comments
Significant Other	☐	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	☐	
Diet	☐	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	☐	
Self	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	

General Comments (For Office Use Only)

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Health Survey

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

	You	Relative	When?		You	Relative	When?
Cancer	☐	☐		Hepatitis	☐	☐	
Diabetes	☐	☐		High Blood Pressure	☐	☐	
Emotional Disorders	☐	☐		Rheumatic Fever	☐	☐	
Infectious Diseases	☐	☐		Seizures	☐	☐	
Heart Disease	☐	☐		Tuberculosis	☐	☐	
Sexually Transmitted Diseases: Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes ☐							
Comments:							

Please indicate the use and frequency of the following:

	Yes	No	Amount?		Yes	No	Amount?
Alcohol	☐	☐		Soda Pop	☐	☐	
Coffee/Black Tea	☐	☐		Tobacco	☐	☐	
Recreational Drugs	☐	☐		Water Intake	☐	☐	
Comments:							

Please check the box if any of the following are true:

	Yes		Yes
I have known allergies	☐	I have a pacemaker	☐
I am taking Coumadin/Warfarin	☐	I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs	☐
Comments:			

Please list any medications AND supplements you are current taking. Attach an additional typed sheet if necessary:

Medicine	Dosage	Reason	How Long	Prescribed By	Last Check-Up

Inner Harmony Acupuncture & Oriental Medicine - Health Questionnaire

Health Survey - (continued)

Please rate your symptom with each of the following statements.

1 = never experience 2 = Sometimes experience 3 = frequently experience

	1	2	3		1	2	3
Lack of appetite?	☐	☐	☐	Pain or coldness in the genital area ?	☐	☐	☐
Belching, burping?	☐	☐	☐	Recent use of antibiotics?	☐	☐	☐
Excessive appetite?	☐	☐	☐	Cough?	☐	☐	☐
Heartburn / reflux?	☐	☐	☐	Eye problems ?	☐	☐	☐
Loose stool or diarrhea?	☐	☐	☐	Shortness of breath?	☐	☐	☐
Feeling the retention of food in the stomach?	☐	☐	☐	Jaundice (yellowish eyes or skin) ?	☐	☐	☐
Digestive problems, indigestion?	☐	☐	☐	Decreased sense of smell ?	☐	☐	☐
Obsessive in work, relationships, etc?	☐	☐	☐	Difficulty digesting oily foods?	☐	☐	☐
Vomiting?	☐	☐	☐	Nasal Problems?	☐	☐	☐
Angina Pains?	☐	☐	☐	Gall stones?	☐	☐	☐
Insomnia / Difficulty sleeping?	☐	☐	☐	Skin Problems?	☐	☐	☐
Abdominal Pains?	☐	☐	☐	Feeling of claustrophobia ?	☐	☐	☐
Heart Palpitations?	☐	☐	☐	Light colored stool ?	☐	☐	☐
Chest Pain?	☐	☐	☐	Soft or brittle nails ?	☐	☐	☐
Cold hands & feet ?	☐	☐	☐	Bronchitis ?	☐	☐	☐
Sciatic Pain?	☐	☐	☐	Easily angered or agitated?	☐	☐	☐
Nightmares?	☐	☐	☐	Colitis or diverticulitis?	☐	☐	☐
Mentally restless?	☐	☐	☐	Difficulty in making plans or decisions?	☐	☐	☐
Headaches?	☐	☐	☐	Constipation?	☐	☐	☐
Laughing for no apparent reason ?	☐	☐	☐	Spasms or twitching of muscles?	☐	☐	☐
Hemorrhoids?	☐	☐	☐	Other:	☐	☐	☐

Comments:

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Symptom Survey (for men)

Date of last prostate checkup		PSA Results		Manual Prostate Exam Results	
Lab Results					

Frequency of Urination:	Daytime:	Nighttime:	Color of urine?		☐ Clear ☐ Murky

Symptoms related to prostate:

☐ Prostate Problems	☐ Delayed Stream	☐ Dribbling	☐ Incontinence	☐ Rectal Dysfunction	☐ Back Pain	☐ Groin Pain
☐ Increased Libido	☐ Decreased Libido	☐ Impotence	☐ Premature Ejaculation	☐ Retention of Urine	☐ Testicular Pain	
Other:						

Symptom Survey (for women)

Age of 1st period (menarche)		Are you pregnant?	Yes ☐ No ☐	Last Gynecological Exam	
Age of last period (menopause)		No. of pregnancies		Pap Smear	
No. of days between periods		No. of live births		Mammogram	
No of days of flow		No. of miscarriages		Bone Destiny Scan	
Color of flow		Abortions (Optional)		Results:	
Clots?	Yes ☐ No ☐	Clot Color			

Average no. of pads per day	Day 1	Day 2	Day 3	Day 4	Day +
Have you been diagnosed with: Fibroids ☐ Endometriosis ☐ Ovarian cysts ☐ PID ☐ Other:					
Location of pain: Lower Abdomen ☐ Lower Back ☐ Thighs ☐ Other:					

Other Symptoms (related to menses)	
☐ Vaginal Dryness	☐ Constipation
☐ Headache	☐ Night Sweats
☐ Insomnia	☐ Mood Swings
☐ Discharge	☐ Nausea
☐ Increase Libido	☐ Decreased Libido
☐ Poor Appetite	☐ Diarrhea
☐ Hot Flashes	☐ Swollen Breasts
☐ Ravenous Appetite	

Nature of pain (please indicate before, during or after menses)			
Cramping		Stabbing	
Burning		Aching	
Bloating		Intermittent	
Bearing down sensation		Dull	
Consistent			