HEAVEN | EARTH | HUMANITY

596 Broadway Suite 302, NY, New York 10012 (646) 279-8836

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 ____________________ Work Phone ______________

Cell Phone ___________________ What is the best way of contacting you? ___________________

Occupation ___________________________ Person Responsible for your account ________________

Emergency Contact : Name ___________________________ Phone ___________________________

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

Sex : ☐ Male ☐ Female Height _____ Weight ______ Birth date __________ Age ________

Marital Status : Married Single Divorced Widowed Significant other

# of Children ________________

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	☐	☐	__________
Rheumatic Fever	☐	☐	__________	Emotional Disorders	☐	☐	__________
Infectious Diseases	☐	☐	__________	Tuberculosis	☐	☐	__________

List any medications and supplements you are currently taking: (Continue on back 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 (Eskalith, Lithobid, Lithonate, Lithotabs)

Any allergies, food sensitivities or food cravings/restrictions (i.e. vegetarian, vegan, Kosher) that you have:

____

____

Please indicate any other important information:

____

____

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

____

____

Lab results: (please include copies)

____

____

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) please circle : 1 2 3 4 5 6 7 8 9 10

What is your average energy level? (1 is lowest, 10 highest) please circle : 1 2 3 4 5 6 7 8 9 10

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

# of hours you get sleep per night: ? _____ time goto bed: ? __________ wake up:__________

Do you sleep well? Y / N (if no, describe) Wake feeling rested? Y / N

Difficulty: Falling asleep / staying asleep / waking up

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: ____________________

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:

Symptom Survey

The following is a list of symptoms that you CURRENTLY mayexperience. Please indicate as follows:

No mark ( ) =Never experience Check mark (√) = sometimes experience Plus sign (+) = frequently 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

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 _________ Results:

Mammogram ____________ Bone Density Scan _____________ Results:

# of days between periods _________ # of days of flow _________________ Midcycle Bleeding? Y / N

Average number of tampons/pads you use per day:

1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days ___

Color of menstrual Blood: ____

☐Pale/light red ☐dark red ☐Red ☐dark red/brown ☐Bright red ☐clots

Amount of menstrual Blood: ____

☐Spotting ☐Light ☐Heavy ☐Even throughout ☐Starts /stops

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Hysterectomy ☐ Beast/Uterine/Ovarian Cancer ☐ Other ________________________

Location of Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other:_____________________

Nature of Pain:

☐Mild ☐ Moderate ☐ Severe

(Please indicate before, during or after menses)

Cramping _________ Stabbing _________

Burning ___________ Aching ___________

Dull ______________ Bloating ___________

Consistent ________ Intermittent ________

Bearing down sensation __________________

Other Symptoms related to menses: (please describe)

☐ Discharge ☐ Vaginal dryness ☐ Headache

☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen breasts ☐ Mood swings ☐ Ravenous appetite

☐ Poor appetite ☐ Hot flashes ☐ Night sweats

☐ Increased libido ☐ Decreased libido ☐ Insomnia

Do you experience:

Issue	Frequently	Occasionally	Issue	Frequently	Occasionally
Abnormal PAP Smear			Pain/itching of genitalia		
Yeast Infections			Genital sores/discharge		
Urinary Tract Infections			Breast lumps		
Vaginal discharge odor			Chronic vaginal discharge		
Uterine prolapse			Nipple discharge		

Is your Fertility an issue? (please describe):

What (if any) treatments have you sought for fertility? Success?

Are you sexually active? Y / N

What form of birth control are you currently using? ______________________ 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? ________

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

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

I certify that the information I have provided above is correct and accurate to the best of my knowledge.

______________________________	______________________________	___________
Patient name	Patient Signature	Date

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