BodyWise Acupuncture & Total Wellness

"Balance is the key"

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please feel free to ask. Thank you.

PERSONAL INFORMATION & MEDICAL HISTORY

Name ____ Age _____

Gender: ☐Male ☐Female Height ___'____" Weight _______ lbs.

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partnered # of children________

Have you received acupuncture therapy before? ☐ Yes ☐No

If so, when? ____________ With whom?_________________________

Whom may we thank for referring you to our office: _____________________________________

Please indicate any significant illnesses you or a blood relative (Grandparent, Parent or Sibling) have had:

ILLNESS	YOU	RELATIVE	ONSET DATE	**ILLNESS**	YOU	RELATIVE	ONSET DATE
Cancer				Diabetes			
Hepatitis				Heart Disease			
High Blood Pressure				Seizures			
Rheumatic Fever				Emotional Disorders			
Infectious Diseases				Tuberculosis			

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐Chlamydia ☐Herpes

Please list any medications and supplements you are currently taking: (continue on back, if needed)

Medicine/Supplement	**Dosage**	**Reason**	**How long taking?**

Check the box if any of the following statements are **TRUE**:

☐ I have known allergies ☐ I am taking Coumadin/Warfarin/anticoagulant

☐ I have a pacemaker/prosthetic heart valve ☐ I am taking Lithium (Eskalith, Lithobid, etc.)

Please indicate the use and frequency of the following:

ITEM	YES	NO	IN THE PAST	HOW MUCH AND HOW FREQUENTLY?
Coffee/black tea				
Non-medical drugs				
Tobacco				
Alcohol				
Water Intake				
Soda Pop				

CHINESE MEDICINE SYMPTOM SURVEY

Mark symptoms with: (**+**) if often, (**√**) if sometimes, blank if not at all.

WOOD	FIRE	EARTH	METAL	WATER
Eye problems	Insomnia	Lack of appetite	Cough	Low back pain
Jaundice (yellowish eyes/skin	Heart palpitations	Excessive appetite	Shortness of breath	Knee problems or pain
Bitter taste in mouth	Mental restlessness	Loose stools/diarrhea	Nasal problems	Hearing impairment
Gallstones	Cold hands & feet	Digestive problems	Skin problems	Ear ringing
Heartburn/acid reflux	Nightmares	Vomiting	Claustrophobia	Kidney stones
Soft/brittle nails	Chest pain/angina	Gas or bloating	Bronchitis	Decreased libido
Easily angered/frustrated	Laughing for no reason or when inappropriate	Obsessive or worrier	Constipation AND/OR Hemorrhoids	Hair loss
Rib side pain/sciatica	Sweat easily	Crave sweets	Colitis/diverticulitis	Urinary problems
Depression or sighing	Agitation/fidgeting	Easily bruised	Grief/nostalgia	Edema
Headaches/dizziness	Poor memory	Fatigue	Catch colds easily	Asthma

REVIEW OF SYSTEMS (*please check all that apply*):

General

☐ Poor Appetite
☐ Hearing Loss
☐ Easy to Bleed or Bruise
☐ Strong Thirst
☐ Puffiness or Swelling
☐ Night Sweats
☐ Changes in Appetite
☐ Weakness
☐ Fevers
☐ Sweat Easily
☐ Poor Sleep
☐ Poor Balance
☐ Cravings
☐ Sudden Energy Drops
☐ Chills
☐ Fatigue
☐ Tremors
☐ Weight Loss
☐ Weight Gain

Skin & Hair

☐ Rashes
☐ Skin Ulcers
☐ Hives
☐ Itching
☐ Eczema
☐ Pimples
☐ Dandruff
☐ Hair Loss
☐ Recent Moles

Head, Eyes, Ears, Nose, and Throat

- ☐ Dizziness
- ☐ Toothache
- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Ear Ringing
- ☐ Sinus Problems
- ☐ Taste/Smell Problems
- ☐ Headaches
- ☐ Concussions
- ☐ Eye Strain/Pain
- ☐ Night Blindness
- ☐ Poor Hearing
- ☐ Nose Bleeds
- ☐ Facial Pain
- ☐ TMJ Pain
- ☐ Migraines
- ☐ Ear Aches
- ☐ Spots in Front of Eyes
- ☐ Recurrent Sore Throat
- ☐ Lip/Tongue Sores
- ☐ Floaters

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Cold Hands or Feet
- ☐ Blood Clots
- ☐ Palpitations
- ☐ Swelling of Hands
- ☐ Swelling of Feet
- ☐ Chest Pain

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty Breathing
- ☐ Phlegm
- ☐ Coughing Up Blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Painful Breathing
- ☐ Easily Winded

Gastro-Intestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bad Breath
- ☐ Ulcers
- ☐ Abdominal Pain
- ☐ Chronic Laxative Use
- ☐ Vomiting
- ☐ Intestinal Gas
- ☐ Indigestion
- ☐ Rectal Pain
- ☐ Belching
- ☐ Blood in Stools
- ☐ Hemorrhoids
- ☐ Acid Reflux

Urology

- ☐ Painful Urination
- ☐ Urgency to Urinate
- ☐ Unable to Hold Urine
- ☐ Decrease in Urine Flow
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Kidney Stones
- ☐ Night Urination
- ☐ Pain in Groin Area
- ☐ STD's

Neuro-Psychological

- ☐ Seizures
- ☐ Areas of Numbness
- ☐ Concussion
- ☐ Twitches
- ☐ Lack of Coordination
- ☐ Depression
- ☐ Irritability
- ☐ Loss of Balance
- ☐ Stress
- ☐ Poor Memory
- ☐ Anxiety
- ☐ Mood Swings
- ☐ Tremors

Musculo-Skeletal

- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Muscle Cramping
- ☐ Muscle Spasms
- ☐ Scoliosis
- ☐ Weak Joints
- ☐ Pain with Weather Changes
- ☐ Pain with Activity
- ☐ Pain after Waking

FEMALES ONLY: OB/GYN HISTORY

Age of 1st period (menarche) _________ Date of last period ______________________

Length of cycle____________ # of days of flow __________ Color of flow _____________________

I have: *(check all that apply)*

☐Irregular menstruation ☐Heavy flow ☐Light flow

☐No flow ☐Clots ☐Vaginal itching/burning

☐Spotting between periods ☐Cramps/ Dysmenorrhea ☐Mid Cycle Spotting/ Pain

If you have clots, what is their color and size? ____

If menstrual pain, what is the location? ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other _______

Nature of pain (please indicate if right before, during or right after menses):

Cramping _______________ Stabbing _______________ Burning______________________

Aching _________________ Dull ___________________ Bloating _____________________

Consistent ______________ Intermittent ____________ Bearing down _________________

Average # of pads you use per day: 1st day ____ 2nd day ____ 3rd day ____ 4th day ____ + days ____

Other Symptoms related to menses (*check all that apply*):

☐ Discharge ☐ Vaginal dryness ☐ Headache

☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Swollen breasts ☐ Mood swings ☐Ravenous appetite

☐Poor appetite ☐Hot flashes ☐Night sweats

☐Increased libido ☐ Decreased libido ☐Insomnia

Have you been diagnosed with (*check all that apply)*:

☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Other _____________

Are you pregnant? ☐ Yes ☐ No

#of pregnancies ______ # of Live births ______ # of Abortions ______ # of Miscarriages ______

Current method of contraception ____

Date of last: Gynecological Exam _______ Pap Smear_______ Mammogram _______ Bone Density ____

Results of above exams: ____

Menopause (if applicable, date of onset) _______________ Any bleeding since? ☐ Yes ☐ No

Menopause Symptoms: ____

Hormone Replacement Therapy? ☐ Yes ☐ No if yes, how long? ________ Side effects? _________

MALES ONLY: UROGENITAL HISTORY

Date of last prostate checkup ____________
PSA Results ___________ Manual prostate exam results __________
Frequency of Urination: daytime (# of times) __________ nighttime (# of times) ____________
Color of urine: ☐ clear ☐ murky
Does your urine have an odor? ☐Yes ☐ No if yes, describe ______________________________
Is it painful when you urinate? ☐Yes ☐ No
Is there a burning sensation when you urinate? ☐Yes ☐ No
*Symptoms related to prostate (*check all that apply*):

☐Prostate problems	☐Erectile dysfunction (E.D.)	☐Back pain
☐Delayed stream	☐Increased libido	☐Groin pain
☐Post void dribbling	☐Decreased libido	☐Testicular pain
☐Incontinence	☐Premature ejaculation	☐Decreased force of stream
☐Retention of Urine	☐Impotence	☐BPH/Enlarged prostate

HEALTH HISTORY

Please indicate your **top 3 health concerns** for which you are seeking treatment and **how long you have been experiencing them**:

1. ____
2. ____
3. ____

What other forms of treatment have you sought?

____

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

____.

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

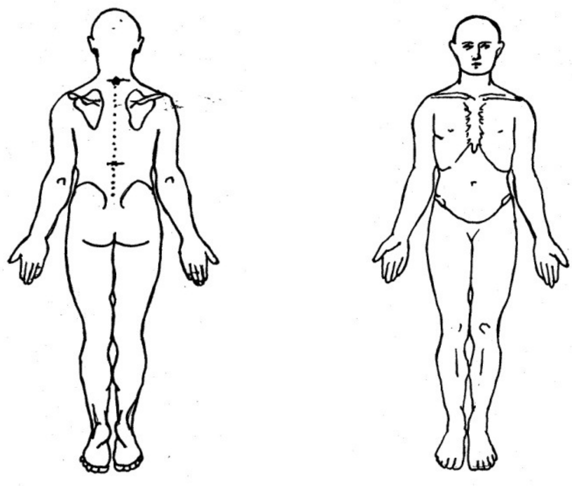
____

____.

Lab results: (please include copies) ____.

Mark location(s) of pain,

if any, on the diagram:



How do you **FEEL** about the following areas of your life? (please check the boxes and indicate any problems or concerns that you may be experiencing in the Comments box)

	Great	Good	Fair	Poor	Bad	Comments
Significant Other						
Family						
Diet						
Intimacy						
Self						
Work						
Exercise						
Spirituality						

Please describe your short-term health goals:

____

____

Please describe your long-term health goals:

____

____

How many hours do you work per week? _________

What do you do in order to manage your stress and take care of yourself?

____

____

Did we miss anything? Is there anything else that you would like for us to know?

THANK YOU!

Patient Signature: X	**Date:**