



Jessica M.S. Gregory, M.S.A.O.M., L.Ac., Dipl. O.M. (NCCAOM)
 9 Carlton Avenue
 E. Setauket, New York 11733
 (631) 689-7848

Acupuncture and Oriental Medicine: Health History Questionnaire

Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: (home) _____ (cell) _____ (work) _____

May we leave phone messages for you at the above phone numbers? Yes No

Email: _____

May we contact you via mail or email with newsletters/special offers? Yes No

How did you hear about us: _____

Sex: M F Birthdate: ____/____/____ Age: ____

Single Married/Partnership Divorced Widowed Separated

Occupation: _____ Employer: _____

Spouse/Partner Name: _____

Emergency Contact: _____ Phone: _____

Please describe condition(s) for which treatment is sought:

1. _____

Date of onset of symptom(s) _____ Severity of symptoms 1-10 (1 mild/10 severe) _____

Have you seen your physician about this condition? Yes No If yes, who? _____

2. _____

Date of onset of symptom(s) _____ Severity of symptoms 1-10 (1 mild/10 severe) _____

Have you seen your physician about this condition? Yes No If yes, who? _____

3. _____

Date of onset of symptom(s) _____ Severity of symptoms 1-10 (1 mild/10 severe) _____

Have you seen your physician about this condition? Yes No If yes, who? _____

Have you had acupuncture before? Yes No

Have you used Chinese herbal medicine? Yes No

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Please list any **vitamins, minerals, herbs, supplements, or homeopathic remedies** that you are presently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list **allergies** that you have to any of the following:

Metal: _____

Medication: _____

Food: _____

Other (i.e., latex, pollen, paint, etc.) _____

Past Medical History:

Please list past injuries, broken bones, surgeries and hospitalizations, with approx. dates.

Please indicate if any of the following apply to you:

- | | | | | | |
|-------------------|------------------------------|-----------------------------|------------------|------------------------------|-----------------------------|
| Hemophilia: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vegetarian/Vegan | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lung condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anticoagulant use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke/CVA | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are you pregnant?/Is there a chance that you are pregnant? Yes No

Lifestyle/Habits:

Exercise:

- Mostly sedentary Mild exercise Occasional vigorous exercise
 Regular vigorous exercise Extreme exercise

Diet:

Are you on a restrictive diet? Yes No

Is your diet physician prescribed? Yes No

Condition diet is meant to treat: _____

Style/Type of diet: _____

of meals eaten in average day: _____

Estimated oz. of water/day: _____ Estimated oz. of other fluids/day: _____

Do you consider your diet "healthy"? Very Somewhat No

Caffeine Intake:

- None Coffee Tea Cola/performance drinks

of cups/cans per day: _____

Alcohol Consumption:

Do you consume alcohol? Yes No

Type of alcohol consumed: _____

of drinks/week: _____

Tobacco Use:

Do you use tobacco? Yes No # of years used: _____

Cigarettes: Packs/day _____ Chew: #/day _____ Pipe/cigar#/day _____

Recreational Drug Use:

Do you use recreational drugs Yes No

Type of Drug: _____ Frequency: _____

General Health Inquiry:

Please indicate if you regularly experience any of the following.

General:

- Cold hands/feet Always feel hot Always feel cold Fever and chills
 Recent unexplained weight changes Fatigue

Musculoskeletal:

- Stiff neck Neck pain Muscle pain Cramps/spasms
 Upper back pain Lower back pain Hand/wrist pain Shoulder pain
 Elbow pain Hip pain Knee pain Foot/ankle pain
 General pain/stiffness Joint(s) with limited range of motion _____
 Other: _____

Head and Neck

- Dizziness Fainting Enlarged lymph glands
 Headache Migraine Concussion(s)
 Other: _____

Eyes & Ears:

- Blurred vision Visual changes Spots/floaters Eye pain
 Dry eyes Poor night vision Red/burning/itching eyes Earache
 Vertigo Ringing in ears Chronic ear infection Decreased hearing
 Glasses/contacts Excessive eye tearing Cataracts/glaucoma Ear discharge
 Other: _____

Respiratory/Nose:

- Cough Coughing up blood Cough with phlegm Difficulty breathing
 Chronic Cough Shortness of breath Wheezing/asthma Frequent colds
 Bronchitis Pneumonia Nasal congestion Hay fever/allergies
 Nosebleeds Sinus infection Pain with breathing
 Other: _____

Mouth & Throat:

- Bleeding gums Recurrent sore throat Bitter taste in mouth Dry mouth
 Tongue/mouth sores Difficulty swallowing Lump in throat Excessive saliva
 Teeth problems Gum problems TMJ Grinding teeth
 Other: _____

Cardiovascular:

- Heart palpitations Chest pain/tightness Poor circulation Varicose veins
 Irregular heart beat Swelling feet/ankles High blood pressure Low blood pressure
 Swelling of hands Swelling in face Blood clots Phlebitis
 Rapid heartbeat Irregular heartbeat Heart murmur
 Other: _____

Skin:

- Hives/Rashes Acne Dry skin Eczema/psoriasis Bruise easily
 Itchy skin Dandruff Sweat easily Spontaneous sweat Night sweats
 Changes in moles/lumps Brittle/weak nails Ulcerations Hair Loss
 Fungal infections Change in hair or skin texture
 Other: _____

Muscles & Joints:

- Joint pain Body aches/stiffness Generalized weakness Numbness/tingling
 "Heaviness" of body/limbs Joint swelling Joint discoloration Tremors
 Other: _____

Gastrointestinal:

- Nausea Vomiting Gas Belching
 Hiccups Bloating Bad breath Loose/soft stool/diarrhea
 Constipation Anal fissures Hemorrhoids Mucous in stool
 Blood in stool Black stool Laxative use Intestinal pain/cramping
 Abdominal pain Rectal pain/itchiness Acid reflux/heartburn Indigestion
 Alternating diarrhea/constipation Other: _____

Appetite/Thirst:

- Exceedingly hungry Poor appetite Hunger w/no desire to eat Specific cravings
- Excessive thirst Thirst w/no desire to drink No thirst
- Temp of drinks most commonly desired: Very cold Tepid Very Hot
- Other: _____

Genital/Urinary:

- Pain/itching of genitalia Genital lesions/discharge Painful/burning urination
- Frequent urination Excessive or scant urination Blood in urine
- Urgent urination Unable to hold urine Nighttime urination
- Cloudy urine Bedwetting Abnormal urine flow
- Kidney Stone Increased libido Decreased libido
- Urinary tract infection(s) Chronic yeast infections Sores on genitals
- Other: _____

Sleep:

- Sound/restful Trouble falling asleep Trouble staying asleep
- Wake easily/early Dream disturbed Vivid dreaming/nightmares
- Difficulty waking up #of hours of sleep/night _____
- Other: _____

Neurological:

- Seizures Memory loss Loss of balance Areas of numbness
- Tics Lack of coordination Other: _____

Emotions:

- Relaxed/calm Sad/Grief/depressed Fearful Impatient
- Angry/Frustrated Poor memory Anxious Stressed
- Manic Sudden energy drop Time: _____
- Other: _____

Female (if appropriate):

- Age at first menses: _____ # of days in cycle _____ # of pregnancies _____ #of live births _____
- Skipped periods Painful periods Irregular cycles Excessive flow
 - Light flow Spotting Cramping PMS
 - Clots Vaginal discharge Vaginal sores Vaginal dryness
 - Vaginal odor Hot flashes Fibroids/cysts Breast lumps/tenderness
- Duration of menses: _____ First day of last period: : _____ Approx date/year menopause: : _____
- Other: _____

Male (if appropriate):

- Impotence Nocturnal Emission Testicular masses Testicular swelling/pain
- Blood in sperm Premature ejaculation Other: _____

Comments

Please let us know of any other concerns you would like to address:

Thank you for completing this form. The information you have provided will assist us in attending to your healthcare needs. Please review the following acknowledgement and sign below:

I have read and completed all answers to the above questions to the best of my knowledge. It is my duty to inform my practitioner of any possible complications prior to treatment.

Signature of Patient or Representative

Signature

Date

Date