HEATHER SHULTZ ACUPUNCTURE

Date_____

Health Questionnaire

Name_____ Date of Birth_____ Gender: □ F □ M □ T

Preferred Phone _____ □ H □ C □ W Alternate Contact Phone _____ □ H □ C □ W

Address_____ City_____ State_____ Zip_____

Email _____ Social Security #_____ Marital Status □S □M □W □D

Emergency Contact _____ Relationship _____ Phone _____

Primary Insurance_____ Group#_____ ID#_____

Subscriber_____ Relationship to Subscriber_____ Effective Date_____

Subscriber's Date of Birth_____ Subscribers Social Security #_____

Referring Doctor _____ Address _____ Phone _____

Primary Care Doctor _____ Address _____ Phone _____

Have you ever had acupuncture before? □ Y □ N Condition & Practitioner _____

CHIEF HEALTH CONCERN Please describe the reason you are seeking acupuncture treatment:

_____

_____

_____

How long have you experienced this health concern? _____

Have you seen a physician for this concern? □yes □no If yes, please indicate date of last visit and name of provider:

_____

Have you sought other forms of treatment for this concern? □yes □no If yes, please indicate what forms of treatment:

_____

Has anything helped you with this health concern? □yes □no If yes, indicate what has helped you:

_____

Has anything made your current health concern worse? _____

CHECK ANY THAT APPLY:

□ I have a pacemaker □ I have a defibrillator □ I have a metal surgical implant

□ I take Coumadin/Warfarin/daily aspirin □ I am allergic to latex □ I am or may be pregnant

□ Other Allergy (please list) _____

Current Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.)

Drug Name and Dose	Frequency	Drug Name and Dose	Frequency
1)		4)	
2)		5)	
3)		6)	

Surgeries and Hospitalizations

Surgery/Procedure Type	Date	Hospitalization Reason	Date
1)		1)	
2)		2)	
3)		3)	

Social History Please indicate if you have in the (Past), current (Current), or never (Never) any of the following

	P	C	N	
Do you smoke?				If past or current, how many packs per day? How many years?
Do you drink alcoholic beverages?				If past or current, how much per week?
Caffeine usage?				If past or current, how many cups per day?
Have you ever worked with chemicals, paints, asbestos or other hazardous materials?				If yes, please explain:
Do you follow any specific diet?	Yes No			If yes, please explain:
Do you exercise on a regular basis?	Yes No			If yes, please explain:

Prevention

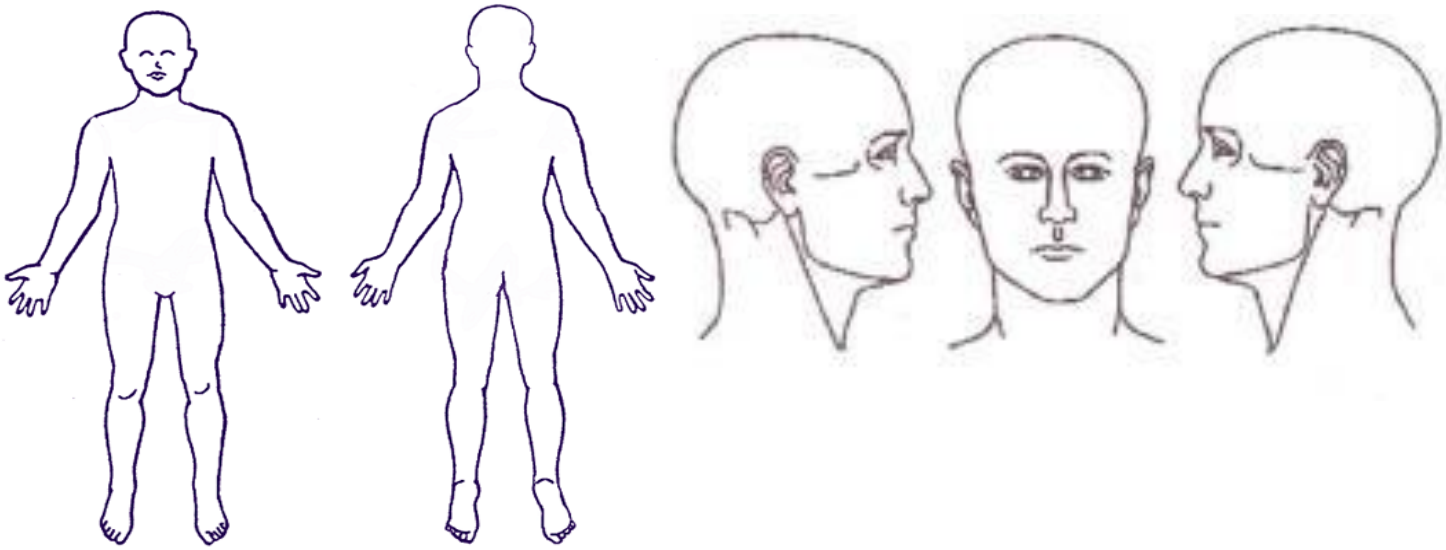
	Yes	**No**	
Do you wear seat belts?			If no, why not?
Do you wear a bike helmet?			
If there is a gun in your home, do you keep unloaded and out of children's reach?			
Have you ever engaged in any activity which has put you at risk of getting a sexually transmitted disease?			If yes, explain:
Do you feel safe at home?			
Do you have smoke/carbon monoxide detectors in your home?			

Family History: Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	**Which Family Member**	**Approximate Age When Diagnosed**	**Living or Deceased**
Cancer (describe type)			
Diabetes			
Drug or Alcohol Addiction			
Heart Disease			
Hyperlipidemia			
Hypertension (high blood pressure)			
Mental Disease (anxiety, depression, etc.)			
Stroke			
Other:			

Sleep Habits: Number of hours you sleep (on average) per night: □ 5 or less □ 6 □ 7-8 □ 9 □ 10+
Do you work shift work? □ yes □ no If yes, please indicate shifts and rotation schedule: _____
Stress Management: Do you feel you are stressed? □ yes □ no Do you have a stress management plan? □ yes □ no
If yes, how does stress affect you? _____
Emotional Habits: □Fearfulness □Anger □Indecisiveness □Irritability □Lack of Joy □Worry □Rumination □Grief

PAIN ASSESSMENT: Place an "X" on any area where you experience pain.



Review of Symptoms: Please indicate if you have had problems with (**P**ast), current within the past 30 days (**C**urrent) of the following:

	P	C		P	C		P	C		P	C
Abdominal Pain			Diarrhea			Hives			Rash		
Back Pain			Difficulty Sleeping			Hoarseness			Ringing in Ears		
Bloating/Gas			Difficulty Urinating			Indigestion			Shortness of Breath		
Blood in Stool			Dizziness			Itching			Sinus Problems		
Blood in Urine			Earache			Joint Pain			Sore That Will Not Heal		
Bruise Easily			Ear Ringing			Lack of Bladder Control			Swollen Ankles		
Change in Appetite			Excessive Thirst			Lightheadedness			Unexplained Weight Loss/Gain		
Change in Bowel Habits			Fainting			Muscle Ache/ Tension			Vomiting		
Change in Dental Health			Fatigue			Nausea			Weakness		
Change in Memory			Fever			Nervousness					
Change in Moles			Forgetfulness			Night sweats					
Change in Vision			Frequent Urination			Nosebleeds			Other:		
Chest Pain			Hair Loss			Painful Urination			1.		
Chills			Hearing Loss			Palpitations/Irregular Heartbeat			2.		
Constipation			Headache/ Migraine			Persistent Cough			3.		
Depression			Hemorrhoids			Poor Circulation					

Woman's Health

Age at first menses: _____ Age at menopause: _____

Duration of menses: _____ Number (or range) of days between menses: _____

Sexual preference: _____

Please indicate if you have had problems with (**P**ast), current within the past 30 days (**C**urrent) any of the following:

	P	C		P	C		P	C	Date of Last:
Abnormal Pap Smear			Hot Flashes			Sexually Transmitted Infection			Mammogram:
Abnormal Bleeding			Miscarriage			Vaginal Infections			Menstrual Period:
Breast Lump			Nipple Discharge			Number of Children:			Pap Smear:
Extreme Menstrual Cramps			Painful Intercourse			Are you Pregnant:	**YES NO**		

Men's Health

Date of last prostate check: _____ PSA results/date: _____

Sexual preference: _____

Please indicate if you have had problems with (**P**ast), current within the past 30 days (**C**urrent) any of the following:

	P	C		P	C		P	C	
Breast Lump			Lump in Testicles			Sexually Transmitted Infection			Other:
Erection Difficulties			Prostate Problem			Sore on Penis/Penile Discharge			

I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____

Patient Signature Date

_____ _____

Review By Date