Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire as thoroughly as possible. Some of the questions may seem unrelated to your condition but play a major role in diagnosis and treatment. All information is strictly confidential. Please print clearly in ink.

I. General Patient Information

Name: _____ Sex ☐M ☐F

Date: _____ Email: _____

Address _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of birth: _____

Ag: _____ Height: _____ Weight: _____

Telephone: Home ( ) ____ - _____ Work ( ) ____ - _____ Cell ( ) ____-_____

Partner/Spouse?_____ Years together?_____

Do you have children? _____ How many? _____ Age at the time of your first child's birth?_____

Pets: _____

Education: _____

Occupation: _____ Do you enjoy work? Y N

Referred by: _____

II. Medical History

Major Complaints in order of significance to you:

	Severe	Moderate	Mild	
1.	☐	☐	☐	_____
2.	☐	☐	☐	_____
3.	☐	☐	☐	_____
4.	☐	☐	☐	_____
5.	☐	☐	☐	_____
6.	☐	☐	☐	_____
7.	☐	☐	☐	_____

How do these conditions affect your daily activities? _____

_____

What treatments have you tried for these conditions? _____

_____

Have you seen any results? _____

How long have you experienced your main complaint? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Hospitalizations and Surgeries

Reason:	When:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

How was your childhood health? _____

Please describe any trauma (emotional or physical): _____

_____

Recent Tests:

☐ Blood (which?) ☐ Pap Smear ☐ Mammogram ☐ TB test
☐ Cholesterol ☐ Prostate/PSA ☐ STD ☐ HIV
☐ Thyroid/TSH ☐ Bone Density ☐ Fasting Plasma Glucose (diabetes)
☐ Pelvic exam ☐ FSH ☐ Clinical Skin exam
Other _____

Results and Date _____

X Rays/Scans:

☐ Chest X-ray ☐ Kidney x-ray ☐ G.I. series ☐ PET scan
☐ Colon x-ray ☐ Gall Bladder x-ray ☐MRI ☐ Electrocardiogram
☐ CT or CAT scan ☐ Echocadiogram
Other _____

Results and Date _____

Immunizations:

☐ Flu injections ☐ Hepatitis A ☐ Tetanus ☐ Measles
☐ HPV ☐ Hepatitis B ☐ Polio series ☐ Mumps
☐ Shingles ☐ Typhoid ☐ Immune serum globulin
Other _____
Date _____

Date of last physical examination: _____

Name & address of physician: _____

Phone number of physician: (____) _____ - _____

Please list all vitamins and herbs you are currently taking: _____
_____
_____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Please place an "X" in the appropriate column or columns

	self	mother	father	sibling	spouse	children
cancer or tumors						
diabetes						
blood or bleeding disorders/anemia						
seizures						
high blood pressure/heart disease						
allergies						
stroke						
drug abuse						
depression or mental illness						
Hepatitis A, B, C, D, E						
kidney disorders						
thyroid disorders						
musculo-skeletal disorder						
blood transfusion (if before 1985)						
age of death						

Additional Illnesses and problems:
Check any you have had in the past or currently ('**P**' for past and '**C**' for current)

- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Thyroid Disorder
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Diabetes
- ☐ Pancreatitis
- ☐ Meningitis
- ☐ HIV
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Mononucleosis
- ☐ Paralysis
- ☐ Parkinsons
- ☐ Stroke
- ☐ Migraines
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Vein Condition
- ☐ Fibromyalgia
- ☐ Measles
- ☐ Mumps
- ☐ Malaria
- ☐ Chicken Pox
- ☐ Polio
- ☐ Tuberculosis
- ☐ Rheumatic Fever
- ☐ Hemorrhoids
- ☐ Cancer
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Lupus
- ☐ Scleroderma
- ☐ Ulcerative Colitis
- ☐ Crohns Disease
- ☐ Kidney Stones
- ☐ Gall Stones
- ☐ Hernia
- ☐ Other Hormone disorder
- ☐ Other kidney disorder
- ☐ Other lung disorder
- ☐ Other liver disorder
- ☐ Other pancreas/spleen disorder
- ☐ Other neurologic disorder
- ☐ Other

_____

MEDICINES:
Prescription drugs you are currently taking. For what condition? Dose? How frequently?

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

Over-the-counter medication you are currently taking? _____

III. Personal Lifestyle

Cigarettes/day_____ Coffee/Tea (cups/day)_____What kind?_____
Alcohol (drinks per week)_____ Which types of alcohol?_____

How many glasses of NON-caffeinated, NON-carbonated beverages to you consume/day?_____

Marijuana _____ How often?_____
Other recreational drugs _____

Food cravings:_____

What kind of sugar do you use? (refined sugar, white sugar, brown sugar, sugar free sweetener, splenda, sweet'n low, cane sugar, turbinado, stevia or others):_____

Diet: What might you eat on a typical day?

Breakfast: _____

Lunch: _____

Dinner: _____

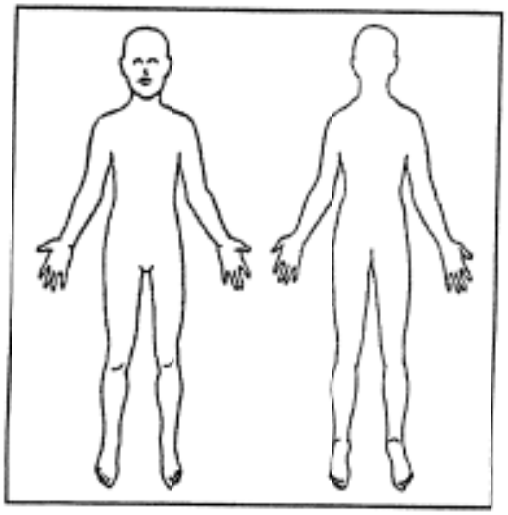
Snacks: _____

Exercise: _____
_____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.)
_____
_____
_____

V. Patient Profile

Please mark any areas of pain:



Is the pain?

☐ Sharp ☐ Aching ☐ Cramping
☐ Dull ☐ Moving ☐ Tingling
☐ Burning ☐ Other _____

Do the following lessen the pain?

☐ Pressure ☐ Heat ☐ Cold
☐ Exercise ☐ Rest
☐ Other _____

Do the following worsen the pain?

☐ Pressure ☐ Heat ☐ Cold
☐ Exercise ☐ Rest
☐ Other _____

Overall Energy (Lung, Kidney function):
- ☐ Fatigue during the day
- ☐ Feel worse after exercise
- ☐ Easily catch colds
- ☐ Shortness of breath
- ☐ General weakness
- ☐ Prolonged recovery from illness
- ☐ Dislike talking
- ☐ Pasty pale complexion

Lung Function:
- ☐ Asthma-difficulty with exhale
- ☐ Allergies
- ☐ Hoarse voice
- ☐ Dry cough
- ☐ Productive cough
  Color of sputum _____
- ☐ Trouble breathing
- ☐ Nose bleeds
- ☐ Nasal discharge
- ☐ Post nasal drip
- ☐ Frequently catch cold
- ☐ Sore throat
- ☐ Dryness of:
  ☐ Nose ☐ Throat ☐ Mouth
- ☐ Alternating fever and chills
- ☐ Achy feeling
- ☐ Sadness or grief

Spleen Funtion:
- ☐ Low appetite
- ☐ Fatigue after eating
- ☐ Sudden weight loss/gain
- ☐ Bloating
- ☐ Gas
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Bruise easily
- ☐ Organ prolapse (bladder or vagina)
- ☐ Loose stool
- ☐ Poor circulation
- ☐ Cold hand and feet
- ☐ Digestive problems
- ☐ Low blood pressure
- ☐ Varicose veins
- ☐ Worry
- ☐ Difficulty focusing
- ☐ Overwhelmed by details
- ☐ Lack strength in arms and legs
- ☐ Sweat without exerting yourself
- ☐ Dizzy or lightheaded when stand too fast
- ☐ Often sick
- ☐ Hypothyroid

Heart function:
- ☐ Palpitations
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent/vivid dreams
- ☐ Restlessness or agitation
- ☐ Easily startled
- ☐ Trouble falling asleep
- ☐ Dull or glazed eyes
- ☐ Chest pain or discomfort
- ☐ Emotional hypersensitivity
- ☐ Tongue sores
- ☐ Fainting
- ☐ Fidgeting
- ☐ Wake up early unable to sleep
- ☐ excess sweating on the chest

Kidney & Bladder Function:
- ☐ Low Back pain
- ☐ Sore, cold or weak knees
- ☐ Frequent cavities
- ☐ Hair loss or premature graying
- ☐ Hearing loss or difficulty
- ☐ Ringing in ears- low pitch/ocean
- ☐ Kidney stones
- ☐ Bone or joint problems
- ☐ Nighttime urination
- ☐ Fear or phobia
- ☐ Dark circles under eyes
- ☐ Memory difficulty
- ☐ Asthma-difficulty with inhale
- ☐ Low libido
- ☐ Urinary tract infections
- ☐ Decreased motivation
- ☐ Urgent urination
- ☐ Difficult or incomplete urination
- ☐ Loss of bladder control

Stomach Function:
- ☐ Stomach pain
- ☐ Belching
- ☐ Hiccoughs
- ☐ Nausea & Vomiting
- ☐ Bulemia
- ☐ Anorexia
- ☐ Burning sensation after eating
- ☐ Headache over forehead region
- ☐ Ulcer (previously diagnosed)
- ☐ Bad breath
- ☐ Bleeding, swollen, painful gums
- ☐ Heartburn, acid regurg, GERD
- ☐ Large appetite
- ☐ Mouth sores

Liver & Gall Bladder Function:

- ☐ Neck and shoulder tension
- ☐ Headaches on top of head
- ☐ Muscle spasms, cramping or twitching
- ☐ Lump in throat/"Plumpit" sensation
- ☐ Difficulty swallowing
- ☐ Itching
- ☐ Tightness under ribs
- ☐ Alternating diarrhea/Constipation
- ☐ Tingling or numbness
- ☐ Migraines
- ☐ Seizures
- ☐ Stroke
- ☐ Anger outbursts
- ☐ Suppressed anger
- ☐ Difficulty making decisions
- ☐ Bitter taste in mouth, esp in a.m. when wake up
- ☐ Dilated pupils
- ☐ Difficulty falling asleep
- ☐ Depression

Blood (Liver, Spleen, Heart Function):

- ☐ Floaters in eyes
- ☐ Dizziness or light headed
- ☐ Anemia
- ☐ Thinning hair on head (overall, not patches)
- ☐ Dry skin or hair
- ☐ Brittle nails
- ☐ Restless sleep
- ☐ Dry mucous membranes
- ☐ Muscles cramping
- ☐ Fatigue with restlessness
- ☐ Dry, hard stool
- ☐ Poor skin healing
- ☐ Periodic numbness in hands or feet, worse at night
- ☐ Varicose or spider veins
- ☐ Periodic numbness in hands or feet, worse at night

Men Only:

- ☐ Premature ejaculation
- ☐ Swollen testicles
- ☐ Testicular pain
- ☐ Cold feeling in genitals
- ☐ Prostatitis
- ☐ elevated PSA

Large & Small Intestine Function:

- ☐ Food intolerance/sensitivity
- ☐ Cramping and pain
- ☐ Gas

Bowel movements:

#/ day _____ or #/week _____

- ☐ Constipation
- ☐ Hard dry stool
- ☐ Blood in stool
- ☐ Mucus in stool
- ☐ Undigested food stuff in stool
- ☐ Burning in anus
- ☐ Urgent or incontinent
- ☐ Incomplete
- ☐ Diarrhea

Temperature (Kidney function):

- ☐ Night sweats
- ☐ Heat sensation in palms, feet & chest
- ☐ Burning sensation on sole of feet
- ☐ Hot flashes any time
  - ☐ Afternoon flush
- ☐ Rosy cheeks with heat sensation
- ☐ Body temp Cold
- ☐ Body temp Hot
- ☐ Thirsty but no desire to drink
- ☐ Thirsty drink in big gulps
- ☐ Thirsty but take small sips
- ☐ Must take water to bed
- ☐ sweating when at rest

Dampness trapped in body:

- ☐ Overweight
- ☐ Urgent, foul smelling stools
- ☐ General sensation of heaviness
- ☐ Tired and sluggish after a meal
- ☐ Snoring
- ☐ Swollen hands and feet
- ☐ Mental fogginess
- ☐ Sluggish
- ☐ Nausea
- ☐ Sinus congestion
- ☐ Pustular acne

Do you feel like your life's path is being or has been fulfilled? _____

VI. Gynecology

Are you currently pregnant? ☐ Y ☐ N Could you possibly be pregnant? ☐ Y ☐ N
Are your periods regular ? ☐ Y ☐ N
Age of first menses: _____ Date of last menstrual period: _____
How many days do you bleed? _____
# of days of entire cycle from Day 1 (day you start bleeding) until next Day 1? _____

Blood clots: ☐ Y ☐ N

Color of menstrual blood: ☐ Light red ☐ Red ☐ Dark red ☐ Brown ☐ Purple

How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy

Current method of contraception: _____
Past method of contraception: _____

	Number	Years
How many pregnancies have you had?	_____	_____
How many live births have you had?	_____	_____
How many miscarriages have you had?	_____	_____
How many times has a D&C been performed?	_____	_____

Have you ever had an abnormal pap spear? ☐ Y ☐ N
Have you ever had a cervical biopsy, operation, cauterization or conization? ☐ Y ☐ N

Date of last pap smear: _____

Have you ever been diagnosed with the following:
☐ Uterine fibroids ☐ Endometriosis ☐ Venereal diseas
☐ Uterine Polyps ☐ Pelvic adhesions ☐ Pelvic abnormalities
☐ Polycystic ovaries ☐ Other: _____

If you have reached menopause please fill out the following:
Menopause (date of onset): _____
Symptoms: _____
Any bleeding since? ☐ Y ☐ N
Are you currently on Hormone Replacement Therapy (HRT)? ☐ Y ☐ N
Dose: _____
How long have you been on HRT? _____
Do you experience any side effects? _____

Kidney Yin deficiency:
☐ Vaginal dryness
☐ Midcycle fertile cervical mucus scanty or absent
☐ Premenstrual low back pain

Spleen Qi deficiency:
☐ Menstrual blood thin, watery, profuse, pink
☐ Spotting few days prior to period
☐ Menstrual cramps with down-bearing sensation in your uterus
☐ Tired around ovulation or menstruation

Kidney Yang deficiency:
☐ Profuse vaginal discharge
☐ Menstrual blood dull in color
☐ Cramps during period that respond to heat pad

Liver Qi Stagnation:
☐ Pre menstrual tension
☐ Premenstrual bloating
☐ Painful menses
☐ Menstrual cramps in external genitals

☐ Loose bowels at beginning of period

Blood stagnation:
☐ Painful unmovable breast lumps
☐ Mid-cycle pain in ovaries
☐ Clots in menstrual blood
☐ Any abnormal lumps in lower abdomen
☐ Piercing, stabbing menstrual cramps

Excess Heat:
☐ Break out with acne premenstrually
☐ Short menstrual cycle
☐ Vaginal irritation or rashes
☐ Breasts sensitive and sore at ovulation
☐ Breasts distention and pain pre-menstrual
☐ Nipple pain or discharge from nipples
☐ Elevated prolactin levels
☐ Menstrual blood thick, dark, purple

Dampness:
☐ Fibrocystic breasts
☐ Menstrual blood contain stringy tissue or mucus
☐ Prone to yeast infections and vaginal itching

Have you ever been treated with acupuncture & or Chinese herbal medicine before? _____

The above information is true to the best of my knowledge

Patient Signature_____Date:_____

Guardian/Parent Signature if applicable_____Date:_____