

DIAMOND STONE ORIENTAL MEDICINE, INC.
Patient History and Health Questionnaire

Name _____ Date _____

Address _____

Home Ph _____ Work Ph _____ Cell Ph _____

Date of Birth _____ Age _____ Weight _____ Height _____ Gender _____

Emergency Contact Name _____ Phone _____

Marital Status _____ Blood Type _____

Primary Health Care Provider _____ Phone _____

Insurance Type _____

Occupation _____ Employer _____

Email Address _____ Fax _____

Referred By _____



Have you ever received acupuncture before? _____

Traditional Chinese Medicine is a system that views the person as a whole. It may not be apparent to you how some of these questions are related to your health problem, but your answers will provide a framework for helping us to understand you as an individual and to effectively treat your condition.

Medical History (include surgeries, childhood illnesses, extended antibiotic treatment, accidents, occupational stressors)

Family Medical History (include major events of first and second degree relatives)

Are you adopted? Yes / No

Lifestyle

Diet

How is your appetite? Increased Decreased No Change

Number of meals per day _____

What tastes/foods do you crave? (please circle all that apply)

Sweet Salty Sour Hot/spicy Bland Crunchy Other

Daily Diet: ___ Std. American Diet (SAD) ___ Vegetarian ___ Whole Foods

Are you often thirsty? Yes / No If yes, for hot? ___ for cold? ___ room temp? ___

Habits

Alcohol: Yes / No Number of drinks per day or week _____

Tobacco: Yes / No What and how much _____

Coffee: Yes / No Cups/day _____ How big is your cup? _____

Soda: Yes / No Amount/day _____

Sweet Treats: Yes / No Amount/Day _____

Stress

Do you feel that your life is stressful? Yes / No Describe _____

Sleep Habits (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Hard to fall asleep | <input type="checkbox"/> Insomnia with indigestion |
| <input type="checkbox"/> Restless dreaming | <input type="checkbox"/> Easy to wake, hard to fall back to sleep |
| <input type="checkbox"/> Wake up too early | <input type="checkbox"/> Wake tired in the morning |

Average number of hours of sleep/night _____

Exercise

Do you exercise regularly? Yes / No How often _____

Type of exercise _____

“Exercise ferments the humors, casts them into their proper channels, throws off redundancies and helps nature in those secret distributions, without which the body cannot subsist in its vigor, nor the soul act with cheerfulness.” Joseph Addison

British Poet/Politician 1672-1719

Please indicate any past or present health complaints by checking the appropriate box and provide a brief explanation if appropriate

Present Past

Head, Eyes, Ears, Nose, Throat

- Headaches
- Migraines
- Neck pain
- Spinal stiffness/tightness
- Dizziness
- Eye pain
- Visual disturbances
- Spots/floaters in eyes
- Recurrent sore throat
- Dry throat
- Dry mouth
- Lump in throat
- Taste in mouth, describe _____
- Smelly breath
- Excess or deficient saliva/mucous
- Sores on lips, tongue or gums
- Sinus problems
- Poor hearing
- Earaches
- Ringing in ears (tinnitus)

Cardiovascular

- Heart palpitations (fluttering sensation)
- Cold hands/feet
- Chest pain/pressure
- Fainting
- High blood pressure
- Low blood pressure
- Heart attack
- Stroke / TIA
- Varicose veins
- Enlarged heart
- Bruising/bleeding

Present Past

Gastrointestinal

- Nausea
- Vomiting
- Abdominal pain or cramps
- Belching
- Gas
- Heartburn (acid reflux)
- Ulcers
- Constipation/diarrhea
- Loose stools
- Irritable bowel/spastic colon
- Black stools
- Blood in stool
- Rectal pain
- Hemorrhoids
- Hepatitis
- Liver/gallbladder disorder
- Diabetes
- Anorexia
- Bulimia

Respiratory

- Cough
- Bloody sputum
- Pain on deep breathing
- Production of phlegm (color)
- Asthma
- Shortness of breath
- Difficult inhalation/exhalation
- Emphysema
- Nasal discharge
- Post nasal drip
- Sleep apnea/snoring
- Allergies to _____

Present Past

Neuromuscular/skeletal

- Neck pain
- Upper back pain
- Lower back pain
- Shoulder pain
- Elbow/upper arm pain
- Elbow/upper arm numbness/tingling
- Wrist pain
- Hand pain
- Hip/upper leg pain
- Hip/upper leg numbness/tingling
- Knee/lower leg pain
- Knee/lower leg numbness/tingling
- Ankle/foot pain
- Jaw pain/clenching
- Joint swelling/stiffness
- Arthritis
- Rheumatoid arthritis
- Muscular incoordination
- Loss of balance
- Weakness
- Epilepsy
- Numbness/tingling, where _____
- Tremor

Genitourinary

- Pain/burning on urination
- Bladder infections
- Urgency to urinate
- Decrease in flow
- Waking at night to urinate
- Frequent urination
- Delay in starting stream
- Loss of bladder control
- Color of urine (clear, dark, cloudy)
- Blood in urine
- Discharge of mucous
- Kidney stones
- Kidney disorders
- Erectile dysfunction
- Prostate problems

List Physical Scars & Date of Occurrence:

Present Past

Neuropsychological

- Mood swings
- Depression/Anxiety
- Drug/alcohol dependence
- Seizures
- Decreased memory
- Lack of concentration
- Seasonal Affective Disorder
- Startle Easily

Dermatological

- Acne
- Itching, where _____
- Rash
- Purpura
- Eczema
- Psoriasis
- Excessively dry skin
- Hair loss
- Dandruff

Miscellaneous

- General fatigue/poor energy
- Weight loss/gain
- Fever/chills
- Cancer/tumors
- Lymph node removal
- Thyroid Issues
- Systemic Lupus
- HIV/AIDS
- Low sexual function
- Born prematurely

For Women:

Any chance of being pregnant now? _____

of pregnancies ____ Miscarriages ____ Abortions ____

Menstruation:

Regular ____ Irregular ____ Age at menarche ____

Birth Control Pills Yes / No Infertility Yes / No

Period comes every ____ days and lasts ____ days

Cramps Yes / No Describe _____

PMS Yes / No Describe _____

Vaginal Discomfort/Discharge _____

Fibroids ____ Endometriosis ____ PCOS ____

Menopause:

When _____ Hormone Replacement Therapy ____

Do you have associated discomfort at present? _____

Hysterectomy Yes / No Date and Reason _____