ACUPUNCTURE · CHINESE MEDICINE

PACIFIC BRIDGE WELLNESS

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Please complete this questionnaire before your first appointment. Users of ***Adobe Reader 11 and later, or newer versions of Adobe Acrobat*** may fill in the form and click Print or Submit on the last page. **If you are using an older browser or have an older version of Adobe Acrobat Reader, please save this form and print and complete by hand**. All information will be held confidential unless otherwise required by law or you agree this information may be shared for insurance or healthcare reasons. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the Comments section on page 5.

Date:

Name:

Home Phone:

Mobile Phone:

Work Phone:

Address:

City:

State:

Zip Code:

Email:

Referred By:

Age:

Date of Birth:

Height:

Weight:

Sex:

Male ○
Female ○

Marital Status:

Single ○ Separated ○ Divorced ○
Partnered ○ Married ○ Widowed ○

Have you been treated with acupuncture or Chinese medicine before? Yes ○ No ○

Occupation:

Employer:

Primary Care Physician:

What is your main health concern?

How long ago did this problems begin?

Is there a known cause/instigating factor?

To what extent does this problem interfere with your daily activities?

Have you been given a medical diagnosis for this problem? If so, what?

What kind of treatment(s) have you tried?

Past Medical History (please include the diagnosis date)

- ☐ Cancer Date: _____
- ☐ Diabetes _____
- ☐ Hepatitis _____
- ☐ High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Rheumatic Fever _____
- ☐ Thyroid Disease _____
- ☐ Seizures _____
- ☐ HIV _____
- ☐ STDs _____
- ☐ Other: Date: _____

List any surgeries and dates:

Traumas (auto accidents, falls, etc.):

Allergies (drugs, foods, etc):

Family Medical History

- ☐ Cancer
- ☐ Diabetes
- ☐ Eye Disease
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ TB
- ☐ Mental Disorders
- ☐ Drug Addiction
- ☐ Stroke
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ HIV
- ☐ STDs
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Alcoholism
- ☐ Allergies
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Ulcers
- ☐ Epilepsy
- ☐ Spinal Problems
- ☐ Other:

Current Medications Taken Within the Last Month (name/dosage):

Vitamins/Supplements/Herbs Taken Within the Last Month:

Do You Have a Regular Exercise Program?

Please Describe Your Average Daily Diet:

Morning:

Afternoon:

Evening:

Do you smoke? If so, how many cigarettes per day?

How much coffee, tea, cola and/or alcohol do you drink per week?

Please describe any use of drugs for non-medical purposes:

Rate your stress level on a scale of 1–10 during an average week (1 being low, 10 being high):

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Please select the appropriate circle for any symptoms you have had in the last few months.
1=None/Almost Never 2=Occasional/Mild 3=Frequent/Severe

General:

1	2	3		1	2	3		1	2	3	
○	○	○	Chills	○	○	○	Poor Sleeping	○	○	○	Lack of Coordination
○	○	○	Sweat Easily	○	○	○	Poor Appetite	○	○	○	Loss of Balance
○	○	○	Night Sweats	○	○	○	Weight Gain	○	○	○	Vertigo/Dizziness
○	○	○	Bleed/Bruise Easily	○	○	○	Weight Loss	○	○	○	Areas of Numbness
○	○	○	Fatigue	○	○	○	Seizures	○	○	○	Poor Memory
○	○	○	Strong Thirst (hot/cold drinks)	○	○	○	Dental/Gum Problems				

Skin & Hair

1	2	3		1	2	3		1	2	3	
○	○	○	Itching	○	○	○	Acne	○	○	○	Dandruff
○	○	○	Eczema	○	○	○	Recent Moles				
○	○	○	Hives	○	○	○	Loss/Thinning of Hair				

Other:

Head, Eyes, Ears, Nose & Throat:

1	2	3		1	2	3		1	2	3	
○	○	○	Dizziness	○	○	○	Night Blindness	○	○	○	Nose Bleeds
○	○	○	Migraines	○	○	○	Eye Pain	○	○	○	Sinus Congestion
○	○	○	Headaches	○	○	○	Cataracts	○	○	○	Grinding Teeth
○	○	○	Poor Vision	○	○	○	Hearing Loss	○	○	○	Concussion
○	○	○	Blurry Vision	○	○	○	Ringing in Ears	○	○	○	Recurrent Sore Throat/Colds
○	○	○	Spots in Front of Eyes	○	○	○	Earaches				

Other:

Cardiovascular:

1 2 3		1 2 3		1 2 3	
○ ○ ○	High Blood Pressure	○ ○ ○	Cold Hands/Feet	○ ○ ○	Difficulty Breathing
○ ○ ○	Low Blood Pressure	○ ○ ○	Fainting	○ ○ ○	Varicose/Spider Veins
○ ○ ○	Chest Discomfort/Pain	○ ○ ○	Blood Clots		
○ ○ ○	Heart Palpitations	○ ○ ○	Swelling of Hand/Feet		

Other: _____

Respiratory:

1 2 3		1 2 3		1 2 3	
○ ○ ○	Cough	○ ○ ○	Asthma/Wheezing	○ ○ ○	Production of Phlegm?
○ ○ ○	Bronchitis	○ ○ ○	Fainting		Color of Phlegm: _____

Other: _____

Gastrointestinal:

1 2 3		1 2 3		1 2 3	
○ ○ ○	Bad Breath	○ ○ ○	Acid Reflux/GERD	○ ○ ○	Rectal Pain
○ ○ ○	Nausea	○ ○ ○	Bloating	○ ○ ○	Hemorrhoids
○ ○ ○	Vomiting	○ ○ ○	Constipation	○ ○ ○	History of Gallbladder Attacks or Stones
○ ○ ○	Belching	○ ○ ○	Intestinal Gas		
○ ○ ○	Diarrhea/ Loose Stools	○ ○ ○	Abdominal Pain/ Cramps		

Other: _____

Genitourinary:

1 2 3		1 2 3		1 2 3	
○ ○ ○	Pain on Urination	○ ○ ○	Prostatitis	○ ○ ○	Impotence
○ ○ ○	Urgency to Urinate	○ ○ ○	Decrease in Urine Flow	○ ○ ○	Change in Sexual Drive
○ ○ ○	Frequent Urination	○ ○ ○	Unable to Hold Urine	○ ○ ○	Decreased Libido
○ ○ ○	Blood in Urine	○ ○ ○	Dribbling	○ ○ ○	Excessive Libido
○ ○ ○	Burning Urination	○ ○ ○	Kidney Stone(s)	○ ○ ○	Genital Sores
○ ○ ○	Urinary Tract Infection	○ ○ ○	Pain in Testicles	○ ○ ○	Herpes

Do you wake up to urinate? Yes ○ No ○ If yes, how often per night? _____

Other: _____

Gynecology/Reproductive:

1 2 3		1 2 3		1 2 3	
○ ○ ○	Painful Periods	○ ○ ○	Breast Lumps	○ ○ ○	Ovarian Cysts
○ ○ ○	Irregular Periods	○ ○ ○	Hot Flashes	○ ○ ○	Endometriosis
○ ○ ○	Clots	○ ○ ○	Vaginal Sores	○ ○ ○	Uterine Fibroids
○ ○ ○	PMS	○ ○ ○	Painful Intercourse	○ ○ ○	Facial Hair Growth
○ ○ ○	Nipple Discharge	○ ○ ○	Infertility	○ ○ ○	Polycystic Ovarian Disease
○ ○ ○	Increased Vaginal Pain, Dryness or Itching	○ ○ ○	Unusual Vaginal Discharge		

Gynecology/Reproductive (continued):

Number of Pregnancies:	_____	Date of Last Menses:	_____
Number of Births:	_____	Date of Last Pap/Pelvic:	_____
Number of Ectopic Pregnancies:	_____	Any Abnormalities?	
Number of Miscarriages:	_____		_____
Number of Abortions:	_____	Menopause Age:	_____
Age of First Menses:	_____	Menopause Year:	_____
Period Between Menses:	_____	Do you Practice Birth Control?	Yes ◯ No ◯
Duration of Menses:	_____	If so, what type and how long?	
Menstrual Flow: Light ◯ Moderate ◯ Heavy ◯			_____

Other: _____

Musculoskeletal:

1 2 3		1 2 3		1 2 3	
◯ ◯ ◯	Neck Pain	◯ ◯ ◯	Hand/Wrist/Arm Pain	◯ ◯ ◯	Muscle Pain
◯ ◯ ◯	Shoulder Pain	◯ ◯ ◯	Hip Pain	◯ ◯ ◯	Muscle Weakness
◯ ◯ ◯	Back Pain	◯ ◯ ◯	Knee Pain		
◯ ◯ ◯	Sciatica	◯ ◯ ◯	Foot/Ankle Pain		

Other: _____

Psychological:

1 2 3		1 2 3		1 2 3	
◯ ◯ ◯	Irritability	◯ ◯ ◯	Anxiety	◯ ◯ ◯	ADD/ADHD
◯ ◯ ◯	Depression	◯ ◯ ◯	Easily Susceptible to Stress	◯ ◯ ◯	Seasonal Affective Disorder
◯ ◯ ◯	Manic Depression				

Other: _____

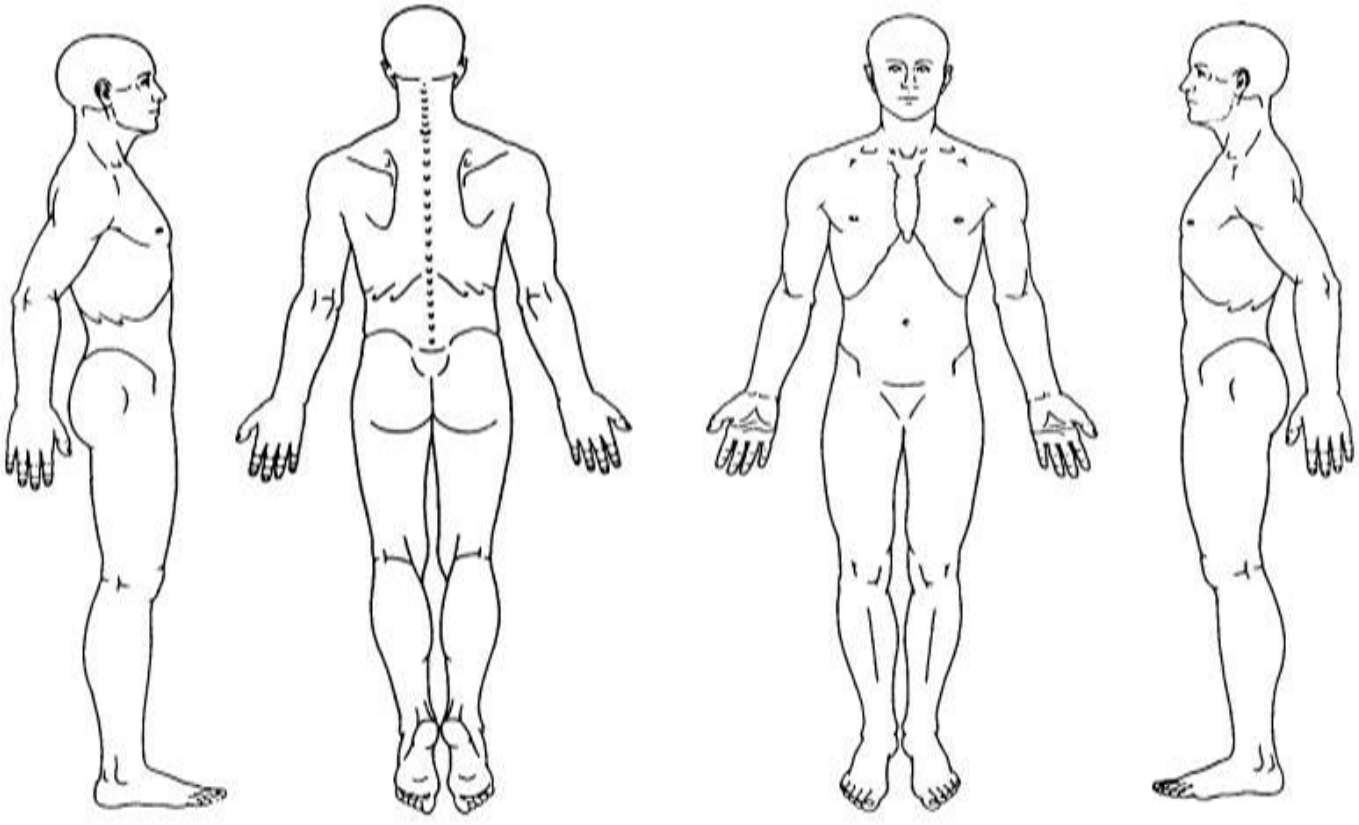
Have you ever been treated for emotional problems? Yes ◯ No ◯

Have you ever considered or attempted suicide? Yes ◯ No ◯

Have you ever been treated for substance abuse? Yes ◯ No ◯

Comments: Is there anything else you would like to discuss?

Indicate Painful or Distressed Areas (please mark after printing or during first visit):



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