Wright Acupuncture for Total Wellness, LLC
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Initial Health Questionnaire

PERSONAL INFORMATION (please print)

Name____ Date of Birth______________________

Home Address____

City_________________________________ State__________________ _Zip Code___________________

Home Phone___________________________ Cell Phone_______________________________________

E-Mail Address________________________________

Gender: □ female □ male □ transgender Height: ___________ Weight: ______________

Did someone refer you to this office? □ yes (please indicate name: __________________________) □ no

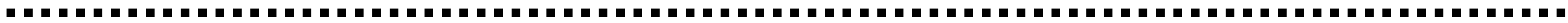
Occupation: _____________________________ Current Employer: ________________________________

Emergency Contact____Phone________________________

Have you ever had acupuncture before? □ yes □ no

If yes, please indicate condition and practitioner : ____

Name of Primary Care Physician: _____________________________________Phone_____________________



CHIEF HEALTH CONCERN

1. Please describe the reason you are seeking acupuncture treatment: _______________________________
____
____
____

2. How long have you experienced this health concern? ____

3. Have you seen a physician for this concern? □ yes □ no

   If yes, please indicate date of last visit and name of provider: ________________________________

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

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

6. Please indicate anything that you feel makes your current health concern worse: _________________________

____

____

PERSONAL HABITS: Please check any/all that apply and indicate amount in spaces provided.

□ Use of tobacco
___ number of cigarettes/day ___ number of years smoking ____stopped smoking (indicate date: ___________)

□ Use of alcohol
___ number of drinks/week ____number of years drinking ____ stopped drinking (indicate date: __________)

□ Caffeine intake (coffee, tea, soda, energy drinks)
___ number of cups of coffee/tea per day
___ number of sodas per day
___ number of energy drinks per day

□ Use of marijuana
Indicate frequency: □ daily □ weekly □ monthly □ few times/year
___ stopped using marijuana (indicate date: ___________)

□ Use of street drugs
Specify drug(s) and frequency: ____
___ stopped using street drugs (indicate date: __________)

LIFESTYLE BEHAVIORS: Please check any/all that apply and explain where indicated.

Frequency of Exercise/Physical Activity:
□ Never □ Occasionally (less than once weekly) □ Regularly (2-5 days/weekly) □ Daily
Type of exercise/physical activity: ____
How long do you exercise during each session? ____

Dietary Habits:
Do you follow a particular meal plan? □ yes □ no
If yes, please indicate type: ____
Do you consider yourself to be a vegetarian? □ yes □ no
If yes, please indicate type and for how long: ____
Number of meals and snacks per day: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6+
Do you have any food cravings? □ yes □ no
If yes, please list: ____
Do you use sugar substitutes? □ yes □ no
If yes, please indicate type(s) below.
□ Nutrasweet □ Sweet 'n Low □ Splenda □ Stevia □ Truvia □ Agave
Please indicate amount used daily: ____

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, if applicable: ______________________________

Stress Management:
Do you feel you are stressed? □ yes □ no

If yes, how does stress effect you? ____

____

Do you have a stress management plan? □ yes □ no
If yes, please describe: ____

____

PERSONAL SATISFACTION

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Your Comments
Self	□	□	□	□	______________
Family	□	□	□	□	______________
Significant Other	□	□	□	□	______________
Overall Health	□	□	□	□	______________
Diet	□	□	□	□	______________
Work	□	□	□	□	______________
Exercise	□	□	□	□	______________
Spirituality	□	□	□	□	______________

MEDICATIONS/SUPPLEMENTS

Please list any medications/supplements you are currently taking. Please indicate dosage and frequency.

Medications/Supplements	Dosage	Frequency (ie. daily/twice daily)

Please list any medication allergies that you have: ____
____

MEDICAL HISTORY: Please indicate any illnesses/conditions you or a direct blood relative have or have had.

Illness	You	Relative	Illness	You	Relative
Hypertension	◻	◻	Diabetes	◻	◻
COPD	◻	◻	Heart Disease	◻	◻
Stroke	◻	◻	Asthma	◻	◻
High Cholesterol	◻	◻	Seizure Disorder	◻	◻
HIV	◻	◻	Depression	◻	◻
Cancer	◻	◻	Anxiety	◻	◻
Hepatitis	◻	◻	Bipolar Disorder	◻	◻
Cirrhosis	◻	◻	Rheumatoid Arthritis	◻	◻
Alcoholism	◻	◻	Substance Abuse	◻	◻
Osteoarthritis	◻	◻	Schizophrenia	◻	◻
Multiple Sclerosis	◻	◻	Polycystic Ovary Syndrome	◻	◻
Alzheimer’s Disease	◻	◻	Aneurysm	◻	◻
Lupus	◻	◻	Scleroderma	◻	◻
Osteoporosis	◻	◻	Anemia	◻	◻
Other (list)	◻	◻	Platelet Disorder	◻	◻
________________________________			Thyroid Disorder		

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 ◻

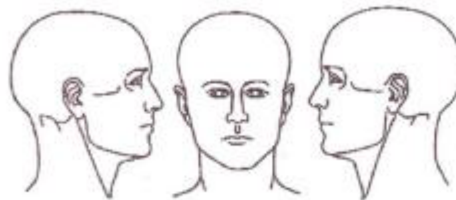
FOR WOMEN ONLY

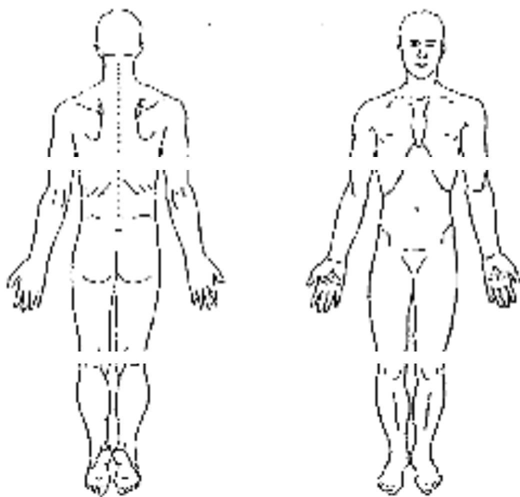
Age at first menses: ___________ Age at menopause: __________
Duration of menses: __________ Number of days between menses: ___________
Please indicate any/all that apply to your menstrual cycle:
Painful periods ◻ Irregular periods ◻ Heavy periods ◻ Light periods ◻
If you experience pain, please indicate the type of pain:
Cramping ◻ Aching ◻ Dull ◻ Stabbing ◻ Burning ◻ Consistent ◻ Intermittent ◻
Please indicate the location of your pain: ____
Number of pregnancies: __________ Number of live births: ________
Number of miscarriages: __________ Number of abortions: _________
Indicate if you have experienced any of the following:
Fibrocystic Breast Disease ◻ Ovarian Cysts ◻ Uterine Fibroids ◻ Endometriosis ◻
Pelvic Inflammatory Disease ◻ Infertility ◻

FOR MEN ONLY

Date of last prostate check: _______________ PSA results/date: ________________
Indicate if you experience any of the following:
Frequent urination ◻ Difficulty urinating ◻ Painful urination ◻ Dribbling urine ◻
Urinary incontinence ◻ Urinary retention ◻ Rectal pain ◻ Testicular pain ◻
Increased libido ◻ Decreased libido ◻ Premature ejaculation ◻ Impotence ◻

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





SYMPTOM SURVEY (FOR ALL): Please indicate all that apply to you by placing a check next to those you sometimes experience and a "+" next to those you experience frequently.

___lack of appetite
___excessive appetite
___loose stool/diarrhea
___digestive problems
___ belching/ burping
___ vomiting
___ heartburn/acid reflux
___ food retention
___ tend to become obsessive
___ insomnia
___ heart palpitations
___ cold hands and feet
___nightmares
___mental restlessness
___ laughing for non reason
___ angina
___ abdominal pain
___ chest pain
___ sciatic pain
___ headaches
___ pain/cold in genital area
___cough
___ shortness of breath
___ decreased sense of smell
___nasal problems
___skin problems
___feeling of claustrophobia
___bronchitis
___colitis/diverticulitis
___constipation
___hemorrhoids
___recent use of antibiotics
___eye problems
___ jaundice
___ hard to eat greasy foods
___gallstones
___ light colored stools
___ soft or brittle nails
___ easily angered
___ difficulty making decisions
___ muscle twitches/spasms
___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones

___ decreased sex drive
___ hair loss
___urinary problems
___fatigue
___ edema
___ swelling
___ bloating
___ blood in stool
___ black stool
___ easily bruised
___ easy to catch cold
___ sudden weight loss
___ sudden weight gain
___ dizziness
___ seasonal allergies
___ food allergies
___ chemical sensitivity
___ easily faints
___ other: ___________________
___other: ____________________