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

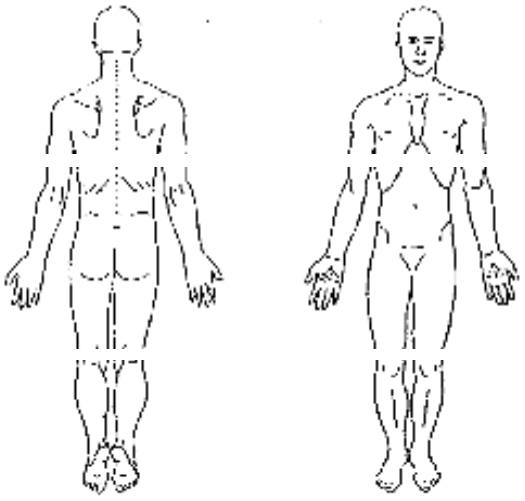
Age at first menses: _____ Age at menopause: _____
Duration of menses: _____ Number of days between menses: _____
Please indicate any/all that apply to your menstrual cycle:
Painful periods □ Irregular periods □ Heavy periods □ Light periods □
If you experience pain, please indicate the type of pain:
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 □

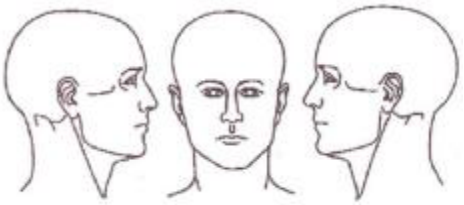
FOR MEN ONLY

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: _____