



Acupuncture and
Oriental Medicine

Confidential Health Questionnaire

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Date:

Name	<input type="text"/>			Home Phone	<input type="text"/>
Address	<input type="text"/>			Cell Phone	<input type="text"/>
City	<input type="text"/>	St	<input type="text"/>	Zip	<input type="text"/>
Occupation	<input type="text"/>			Work Phone	<input type="text"/>
Employer	<input type="text"/>			Extension	<input type="text"/>
eMail Address	<input type="text"/>			EM Phone	<input type="text"/>
Emergency Name	<input type="text"/>				
Who can we thank for referring you?				<input type="text"/>	

Sex - M <input type="checkbox"/> F <input type="checkbox"/>	Height:	Weight:	Age:	Birthday:
Marital Status - Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>	Children:			
Previous Acupuncture	Yes <input type="checkbox"/> No <input type="checkbox"/>	When:	With Whom:	

General Health Questions

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food cravings that you have.

List any accidents, surgeries or hospitalizations & include dates

Inner Harmony Acupuncture & Oriental Medicine - Health Questionnaire

How do you FEEL about the following areas of your life? Please check the boxes 1 being the best you can possibly feel and 5 being the worst. Please then indicate any problems you may be experiencing in the space allowed to the right.

	1	2	3	4	5	Your Comments
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

General Comments (For Office Use Only)

Inner Harmony Acupuncture & Oriental Medicine - Health Questionnaire

Health Survey

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

	You	Relative	When?		You	Relative	When?
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually Transmitted Diseases: Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV <input type="checkbox"/> HPV <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/>							
Comments:							

Please indicate the use and frequency of the following:

	Yes	No	Amount?		Yes	No	Amount?
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		Soda Pop	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee/Black Tea	<input type="checkbox"/>	<input type="checkbox"/>		Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>		Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	
Comments:							

Please check the box if any of the following are true:

	Yes		Yes
I have known allergies	<input type="checkbox"/>		I have a pacemaker <input type="checkbox"/>
I am taking Coumadin/Warfarin	<input type="checkbox"/>	I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs	<input type="checkbox"/>
Comments:			

Please list any medications AND supplements you are current taking. Attach an additional typed sheet if necessary:

Medicine	Dosage	Reason	How Long	Prescribed By	Last Check-Up

Inner Harmony Acupuncture & Oriental Medicine - Health Questionnaire

Health Survey - (continued)

Please rate your symptom with each of the following statements.

1 = never experience

2 = Sometimes experience

3 = frequently experience

	1	2	3		1	2	3
Lack of appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or coldness in the genital area ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching, burping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent use of antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn / reflux?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose stool or diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling the retention of food in the stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellowish eyes or skin) ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems, indigestion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of smell ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive in work, relationships, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty digesting oily foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall stones?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia / Difficulty sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling of claustrophobia ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light colored stool ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft or brittle nails ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands & feet ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sciatic Pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily angered or agitated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis or diverticulitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mentally restless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in making plans or decisions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laughing for no apparent reason ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spasms or twitching of muscles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

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Symptom Survey (for men)

Date of last prostate checkup		PSA Results		Manual Prostate Exam Results	
Lab Results					
Frequency of Urination:	Daytime:	Nighttime:	Color of urine?		<input type="checkbox"/> Clear <input type="checkbox"/> Murky

Symptoms related to prostate:

<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Delayed Stream	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Rectal Dysfunction	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Groin Pain
<input type="checkbox"/> Increased Libido	<input type="checkbox"/> Decreased Libido	<input type="checkbox"/> Impotence	<input type="checkbox"/> Premature Ejaculation	<input type="checkbox"/> Retention of Urine	<input type="checkbox"/> Testicular Pain	
Other:						

Symptom Survey (for women)

Age of 1st period (menarche)		Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Last Gynecological Exam	
Age of last period (menopause)		No. of pregnancies		Pap Smear	
No. of days between periods		No. of live births		Mammogram	
No of days of flow		No. of miscarriages		Bone Density Scan	
Color of flow		Abortions (Optional)		Results:	
Clots?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Clot Color			

Average no. of pads per day	Day 1	Day 2	Day 3	Day 4	Day +
Have you been diagnosed with: Fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian cysts <input type="checkbox"/> PID <input type="checkbox"/> Other:					
Location of pain: Lower Abdomen <input type="checkbox"/> Lower Back <input type="checkbox"/> Thighs <input type="checkbox"/> Other:					

Other Symptoms (related to menses)	
<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Constipation
<input type="checkbox"/> Headache	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Discharge	<input type="checkbox"/> Nausea
<input type="checkbox"/> Increase Libido	<input type="checkbox"/> Decreased Libido
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Swollen Breasts
<input type="checkbox"/> Ravenous Appetite	

Nature of pain (please indicate before, during or after menses)			
Cramping		Stabbing	
Burning		Aching	
Bloating		Intermittent	
Bearing down sensation		Dull	
Consistent			