Myrrh Acupuncture and Herbs

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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

Personal Information

Name_____ Date_____

Home Address _____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone _____ E-mail _____

Occupation_____ Person responsible for your account_____

Who should we thank for referring you to this office? _____

Sex: Male__ Female __ Height_____ Weight_____ Birth date_____ Age____

Marital Status: Married___ Single___ Divorced___ Widowed___ Number of children____

Have you received acupuncture therapy before? Yes__ No__

When?_____ With whom?_____

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

Illness	You	Your relative	Approx. date	Illness	You	Your relative	Approx. date
Cancer	____	____	_____	Diabetes	____	____	_____
Hepatitis	____	____	_____	Heart Disease	____	____	_____
High blood pressure	____	____	_____	Seizures	____	____	_____
Rheumatic Fever	____	____	_____	Emotional Disorders	____	____	_____
Infectious Disease	____	____	_____	Tuberculosis	____	____	_____

Sexually Transmitted Diseases: Gonorrhea___ Syphilis___ AIDS___ HPV___ Chlamydia___ Herpes___ Date_____

List any medications and supplements you are currently taking(continued on back if necessary)

Medicine and Dosage	Reason	How long?	Prescribed by	Date of last check up

Please indicate the use and frequency of the following:

	Yes	No	How much?
Coffee/black tea	___	___	_____
Non-medical drugs	___	___	_____
Tobacco	___	___	_____
Alcohol	___	___	_____
Water intake	___	___	_____
Soda pop	___	___	_____

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 date).

_____
_____

Lab Results (please include copies)

_____
_____

For Women

Age of first period (menarche)_____ Age of last period (menopause)_____

Number of days between periods_____ Number of days of flow_____

Color of flow_____ Clots? Yes___ No___ Color_____

Average number of pads/tampons you use per day:
1st day_____ 2nd day_____ 3rd day_____ 4th day_____ + days_____

Have you been diagnosed with: Fibroids____ Fibrocystic Breasts____

Endometriosis____ Ovarian cysts____ PID____ Other____

Location of pain: Lower abdomen___ Lower back___ Thighs___ Other_____

Nature of pain (please indicate before, during or after menses):

Cramping_____ Stabbing_____ Burning_____
Aching _____ Dull _____ Bloating_____
Consistent_____ Intermittent_____
Bearing down sensation_____

Other symptoms related to menses:

Discharge___ Vaginal Dryness___ Headache___
Nausea ___ Constipation ___ Diarrhea ___
Swollen Breasts ___ Mood swings ___ Ravenous appetite ___
Poor appetite ___ Hot flashes ___ Night sweats ___
Increased libido ___ Decreased libido ___ Insomnia ___

Are you pregnant? Yes___ No___ # of pregnancies _____ # of live births____

# of abortions ____ # of miscarriages ____

Date of last: Gynecologic exam _____ Pap smear_____ Mammogram_____
Bone Density scan_____ Results _____

For Men

Date of last prostate check up _____ PSA results_____

Manual prostate exam results_____

Lab Results:

Frequency of Urination: daytime _____ Nighttime_____

Color of urine: clear ____ murky_____ Odor:_____

Symptoms related to prostate:

Prostate problems	__	Delayed stream	__	Dribbling	__
Rectal Dysfunction	__	Incontinence	__	Retention of Urine	__
Back pain	__	Increased Libido	__	Decreased Libido	__
Premature Ejaculation	__	Impotence	__	Groin pain	__
Testicular pain	__	Other:			

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
NO MARK ( ) = NEVER EXPERIENCE CHECK MARK (√) = SOMETIMES EXPERIENCE
PLUS SIGN (+) = FREQUENTLY EXPERIENCE

___ lack of appetite
___digestive problems, indigestion
___heartburn/ reflux
___excessive appetite
___vomiting
___feeling the retention of food in stomach
___loose stool or diarrhea
___belching, burping
___tendency to become obsessive in work, relationships …

___insomnia, difficulty sleeping
___nightmares
___heart palpitations
___mentally restless
___cold hands and feet
___laughing for no apparent reason
___angina pains
___sciatic pain
___abdominal pains
___headaches
___chest pain
___pain or coldness in the genital area

___cough
___nasal problems
___bronchitis
___hemorrhoids
___jaundice (yellowish eyes or skin)
___light colored stool
___difficulty in making plans/decisions
___shortness of breath
___skin problems
___colitis or diverticulitis
___recent use of antibiotics
___difficulty digesting oily foods
___soft or brittle nails
___decreased sense of smell
___feeling of claustrophobia
___constipation
___eye problems
___gall stones
___easily angered or agitated
___spasms or twitching of muscles

___low back pain
___ear ringing
___hair loss
___edema
___easily bruised
___tendency to catch colds easily
___hay fever
___high cholesterol levels
___knee problems
___kidney stones
___urinary problems
___blood in stool
___difficult to stop bleeding
___intolerance to weather changes
___dizziness
___sudden weight loss.
___hearing impairment
___decreased sex drive
___fatigue
___black tarry stool
___asthma
___allergies
___tendency to faint easily