Point Acupuncture Comprehensive Questionnaire

Note: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.
562-377-0658

Date______________________

NAME____Birthdate ___________________________

Telephone: Cell_______________________ Home __________________________Work________________________________

Address (street, city, state, zip code)____

Single / Married / Domestic Partner / Significant Other / Widowed / Divorced

Occupation____Referred By__________________________________

MAJOR COMPLAINT/S____

____

Date of onset (when you first noticed your problem) ____

Pain/discomfort is: (Minimal) 1 2 3 4 5 6 7 (Severe)

Have you had this in the past? No / Yes When_________

What makes it better?_____________________________

What makes it worse?_____________________________

Is your condition: Getting worse / Constant / Comes and Goes

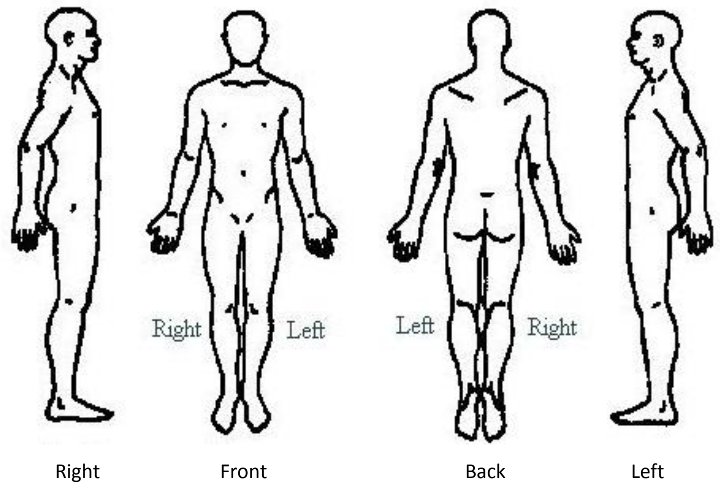
Medications/Drugs/Herbs you are currently taking:

____

List surgeries/operations you have had with the dates:

____

Please mark your areas of pain/discomfort on the diagram below.



MEDICAL HISTORY:
(Circle if you have or have had any of the following)

Arthritis / Asthma / Anemia / Heart Trouble / Cancer / Diabetes / Epilepsy / Stroke / Gallstones / Ulcers / Hepatitis /

High Blood Pressure / Chronic Fatigue / Jaundice / Sudden Weight Loss / Sudden Weight Gain / Scarlet Fever / Rheumatic Fever /

Gonorrhea / Syphilis / Food, Drug Poisoning / Rectal Disease / Pleurisy / Polio / Meningitis / Nervous Breakdown / Pneumonia /

TB / Angina / Hay Fever / Boils / Infections / Alcoholism / Miscarriage / Mental Disorder / Drug Problem / AIDS/ HIV+ /

Broken Bones / Dislocations / Scoliosis / Allergies / Kidney/Bladder trouble / Concussion/Head Injury / Sugar Addiction

Other ____

List any family disease tendency of which you are aware: ____

____

Please circle any symptom that applies to your current condition or that you experience recurrently. Add comments if you need to clarify a condition.

ENERGY LEVEL: Tiredness / Exhaustion can include Poor appetite / Weak voice / Backache / Dizziness / Slight depression / Anxiety / Heavy feeling in body / Tenseness

SWEATING: Night time / Daytime / Excessive sweating / Slight sweating / Rarely sweat / location: Head / Forehead / Hands / Palms / Nose / Arms / Legs / Feet / Soles / Chest / Whole body

CIRCULATION: Bleed, bruise easily / Feverish / Hot / Cold / Shivers / Aching, pain / Dislike wind / Dislike cold / location: Hands / Fingers / Arms / Chest / Legs / Feet / Whole body

SKIN: Greasy / Moist / Dry / Pale / Red / Purple / Blue / Itchy / Scaling / Puffy / Crusty / Hard / Bleeding / Pus-filled / Clear liquid / Weepy / Pain

SCARS: List location of all scars____

SLEEP PROBLEMS: Trouble falling asleep / Trouble staying asleep / Excessive dreaming / Restful

How many hours do you sleep a night? ____________________________

HEAD: Headaches (what area?) Dizziness Memory loss / Loss of balance

EYES: Eye strain / Cross eyed / Eye inflammation / Glaucoma / Eye pain / Dry eyes / Blurred vision / Darkness under eyes

EARS: Ringing/buzzing in ears / Earaches / Ear discharge/infections / Poor hearing

NOSE: Frequent nose bleeds / Sinus trouble / Frequent colds / Allergies / Nasal Obstruction / Nasal drainage / Loss of smell / Hay fever

THROAT: Asthma / Frequent colds / Change in taste / Gum troubles / Hoarseness / Loss of taste / Enlarged glands / Enlarged thyroid / Tonsillitis / Sore throat / Jaw problems / Difficulty swallowing / Swollen tongue / Difficult speech / Teeth or gum problems

CHEST: Hard to breathe / Wheezing / Shortness of breath / Mucus rattles when breathing / Persistent cough / Palpitations / Coughing blood / Trouble breathing at night / Pain/pressure in chest / Coughing phlegm

CARDIOVASCULAR: Rapid beating heart / Slow beating heart / Irregular beating heart / High blood pressure / Low blood pressure / Pain over heart / Previous heart stroke / Hardening of the arteries / Swelling of ankles / Poor circulation / Paralytic stroke / Varicose veins

BOWELS: Diarrhea / Constipation / Bloody stools / Black stools / Mucus in stools / Hemorrhoids / Lower bowel gas / Stools have foul odor / Colon problems

Number of bowel movements a day __________________

URINE: Scanty urine / Pus in urine / Inability to control urine / Discolored urine / Bed wetting / Strong smelling urine / Hard to urinate / Blood in urine / Frequent infections / Water retention! Kidney stones / Burning or pain urinating

Please circle any symptom that applies to your current condition or that you experience recurrently. Add comments if you need to clarify a condition.

APPETITE: Excessive / Poor / Keeps changing / Feel tired if a meal is missed / Excessive thirst / Never thirsty

Specific food cravings? No / Yes, what kind?____

DIGESTION: Stomach gas / Lower bowel gas / Heartburn / Nausea / Burning / Belching / Stomach pain / Stomach cramps /

Vomiting / Bad breath / Sores in mouth / Bitter/sour taste in mouth / weight gain / weight loss / abdominal bloating

Food Allergies? No / Yes, what kind?____

NUTRITION: List some of your favorite foods ____

How many meals a day do you eat? How many cups of water do you drink a day? ________________________________

Do you use: Alcohol? No / Yes Amount per week __________________Type_____________________________________

Tobacco? No / Yes Amount per week __________________________ How many years? ___________________________

MUSCULOSKELETAL: Painful tail bone / Hernia / Spinal curvature / Faulty Posture / Swollen joints / Arthritis

NEUROLOGICAL: Nervousness / Depressed / Easily angered / Easily irritated / Frequent crying / Worry/Anxiety /

Mood swings / Memory confusion / Poor concentration / Suicidal/Tremors / Poor coordination / Muscle weakness /

Feel weak and shaky / Seizures

FEMALES: Pregnant Last monthly period Birth Control: None / Pill /Other ____________

Age started menstrual cycle _______________ Age stopped_______________ Color of blood- Red / Pale / Dark / Purple

Menstrual pain / Low back pain / Irregular cycle / Clotting / Heavy bleeding / Scant bleeding / Water retention /

Mood changes / Missed periods / Painful breasts / Hot flashes / Food cravings

Discharges: Yellow / Thick / White / Itching / Watery

No. Pregnancies _______ No. Deliveries _________ No. Miscarriages _________ No. Abortions ______________

No. Cesareans ________________ Operations: Cervix / Uterus / Ovaries / Other: ___________________________

MALES: Discharges / Prostate trouble / Impotence / Premature ejaculation / Ejaculation causes pain / Genital pain

Burning or pain while urinating