

Acupuncture Health Center

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Thank you for choosing our office!! In order to serve you properly, we need the following information. All information will be kept confidential.

Please Print

Patient Name:			Today's Date:	
Home address:		City:	State:	Zip:
Home phone:		Work Phone	Birth date:	
Email address	Can we use your email for notification Purposes? Yes? No?		Height :	Weight:
Circle appropriate: Minor Single Married Divorced Separated Widowed				
Person to contact in case of emergency:		Their Relationship to you:	Their Phone Number:	
Patient's Occupation:		Who might we thank for referring you?		

Insurance information:

Insurance company:		Referring Physician:	
Patient's (or parent/guardian's) employer:			
Business Address:		City:	State: Zip:
Spouse (or parent/guardian's) Name:		Spouse's Occupation:	
Spouse (or parent/guardian's) Employer:		Spouse's Work phone:	
Office Notes:			

HEALTH HISTORY QUESTIONNAIRE

Have You ever been treated with Acupuncture or Oriental Medicine before?? YES NO
What Main Problem(s) would you like us to help you with?
What Other Medical treatment(s) or alternative therapies have you tried for this problem?

DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

Allergies	High Blood Pressure	Recurrent Infections
Arthritis	High Cholesterol	Recurrent Sore Throats
Asthma	Kidney Disease	Sensitivities
Cancer	Kidney (or Bladder) Stones	Sinus Congestion
Chronic Infections	Liver Disease	Sprains or Bruising
Diabetes	Lung Disorder	Stomach Disorders
Eye Disease	Menopausal Symptoms	Substance abuse
Fatigue	Mental Illness	Tuberculosis Exposure
Food Cravings	Numbness or tingling	Tumor
Gall Bladder Disease	Obesity	Varicose Veins
Heart Disease	PMS	Wear Eyeglasses
Heart Burn	Poor Circulation	Other:
Headaches / Migraines	Psoriasis, Eczema, Acne	Other:
Hemorrhoids	Recent Surgery	Other:

FAMILY HISTORY:

Relatives	If Living		If deceased	
	Age	Health (good, fair, poor)	Death age	Death cause
Father				
Mother				
Brothers/Sisters (Circle sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Spouse				
Sons/ daughters (Circle sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Please list any blood relatives who have or have had any of the following conditions:

	Yes	No	Relationship		Yes	No	Relationship
Alcoholism				High Blood Pressure			
Allergies				Kidney Disease			
Anemia				Leukemia			
Arthritis/ Rheumatism				Mental Illness			
Asthma				Migraine/ Headache			
Bleeding Tendency				Nervous Breakdown			
Cancer				Obesity			
Colitis				Rheumatic Fever			
Congenital Heart				Stomach Ulcers			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Tuberculosis			
Heart Disease/ Stroke				Other:			

Your Personal Habits:

Do you smoke?	YES	NO	If Yes, # of packages per day	
Do you Drink Coffee?	YES	NO	If Yes, # of cups per day	
Do you Drink alcohol?	YES	NO	If yes, # of drinks per day	

If available, please bring your most recent lab/blood work results to your first session. Document your Test Levels of the following, if known:

Blood Pressure Level:	Cholesterol level:
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Check any you are you currently taking or have taken within the last 3 months:

Antacids		Cough Medicine		Steroids
Antibiotics		Herbs		Tranquilizers
Aspirin		Insulin / Diabetic pills		Thyroid medication
Blood Pressure Pills		Iron Pills		Vitamins
Blood Thinning Pills		Laxatives		Water Pills
Birth Control Pills		Sleeping Pills		Weight Reducing Pills

BRIEF HEALTH HISTORY

Operations you have had:	Include Years
Diseases you had requiring hospitalization:	Include Years
Serious Illnesses you had not requiring hospitalization:	Include Years
Describe any serious injuries or accidents you have had:	Include Years
Have you ever worn a neck or back brace?	YES NO
List any known Drug Allergies you have:	

PLEASE LIST YOUR MEDICATIONS:

NAME	DOSAGE	INDICATION	LENGTH OF TREATMENT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PLEASE LIST YOUR SUPPLEMENTS OR OVER THE COUNTER MEDICATIONS:

NAME	DOSAGE	INDICATION	LENGTH OF TREATMENT
1.			
2.			
3.			
4.			
5.			
6.			
7.			

HEART

<input type="checkbox"/>	Normal Blood Pressure	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Dizziness upon standing	<input type="checkbox"/>	Congenital Disease	<input type="checkbox"/>	

Explain:

Professional Notes:

HEADACHES

Do you frequently have Headaches? YES NO (If yes, answer the following):

<input type="checkbox"/>	Cause visual trouble?	<input type="checkbox"/>	Do they occur on the side?	<input type="checkbox"/>	What is the duration?
<input type="checkbox"/>	Awaken you at night?	<input type="checkbox"/>	On the back?	<input type="checkbox"/>	Does aspirin relieve them
<input type="checkbox"/>	Pain is sharp and stabbing	<input type="checkbox"/>	In the front?	<input type="checkbox"/>	Do they involve dizziness or weakness
<input type="checkbox"/>	Pain is dull and achy	<input type="checkbox"/>	At the eyes?		
<input type="checkbox"/>	Pain feels like a tight band?	<input type="checkbox"/>	On top?	<input type="checkbox"/>	Are they aggravated by Overwork?
<input type="checkbox"/>	Head feels heavy?	<input type="checkbox"/>	Sinus area?		

Other Description:

Professional Notes

PAIN:

Location		Constant or Intermittent
Time of day it's worse	Better or worse with cold?	Better or worse with heat?
Better or worse with pressure?	Pain intensity 0-10	Does pain move?
Better or worse with activity?	Is there a heavy feeling?	Is the pain sharp and stabbing?
Is the pain dull and achy?	What is its duration?	
Explain:		
Professional Notes:		

If you have stomach pain, does the pain...

<input type="checkbox"/>	Occur within 1-2 hours after eating	<input type="checkbox"/>	Occur after eating fried foods?	<input type="checkbox"/>	Awaken you at night?
<input type="checkbox"/>	Go away with an antacid?	<input type="checkbox"/>	Go away after a bowel movement?	<input type="checkbox"/>	Cause a loss of appetite?
Explain:					
Professional Notes:					

THIRST

<input type="checkbox"/>	Thirsty	<input type="checkbox"/>	No thirst, but drinks lots anyway	<input type="checkbox"/>	Prefer cold drinks
<input type="checkbox"/>	Absence of Thirst	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	Prefer room temperature drinks
<input type="checkbox"/>	Thirst with little desire to drink	<input type="checkbox"/>		<input type="checkbox"/>	Prefer hot drinks
What do you drink throughout the day?				Quantities:	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
Professional Notes:					

APPETITE and DIGESTION (Check those that apply)

<input type="checkbox"/>	Rapid hungering	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Loss of taste
<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	Canker sores
<input type="checkbox"/>	Hungry, but no desire to eat	<input type="checkbox"/>	Preference for salty food	<input type="checkbox"/>	Toothaches
<input type="checkbox"/>	Not hungry, but desire to eat	<input type="checkbox"/>	Preference for fatty foods	<input type="checkbox"/>	Halitosis
<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Preference for sweets	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Bitter taste in mouth	<input type="checkbox"/>	Undigested food in stool
<input type="checkbox"/>	Bloating	<input type="checkbox"/>	Sweet taste in Mouth	<input type="checkbox"/>	Eating Disorder
<input type="checkbox"/>	Gas/ flatulence	<input type="checkbox"/>	Sour taste in mouth	<input type="checkbox"/>	Other:
Do you consider your weight to be: Normal, Overweight, or Underweight?				How many pounds would you like to gain or lose?	
What is a typical Breakfast for you?			What is a typical Lunch for you?		
What is a typical Dinner for you?			What are typical snacks you eat?		
What foods do you crave?			What foods do you avoid?		
Explanations:					
Professional Notes:					

URINATION

<input type="checkbox"/>	Frequent	<input type="checkbox"/>	Burning	<input type="checkbox"/>	Cloudy	<input type="checkbox"/>	Foul Smell	<input type="checkbox"/>	Difficult start	<input type="checkbox"/>	Large amount
<input type="checkbox"/>	Urgent	<input type="checkbox"/>	Painful	<input type="checkbox"/>	Dark Color	<input type="checkbox"/>	Bloody	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Small amount
<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	History of bladder or kidney infection			Other:					
# of times / day						# of times / night					
Explain:											
Professional Notes:											

BOWEL MOVEMENT:

Constipation	Watery	Thin	With Mucous	Black
Diarrhea	Incomplete	Formed	With Blood	Yellow
Loose	Hard & Dry	Strong Smell	Light to dark brown	Green
# of bowel movements per day:		Explain:		
Professional Notes:				

UPPER RESPIRATORY:

Chronic Cough	Thick sputum	Sore throat	Sinus infection	Sinus headache
Bronchitis	Green sputum	Post nasal drip	Swollen sinus	Wheezing
Profuse, watery sputum	Yellow sputum	Dry sinus	Congestion	Snoring
Explain:				
Have you ever been allergy tested? YES NO				
If yes, what substances did you test positive for?				
Professional Notes:				

VISION

Loss of vision	Eye pain	Eyelid drooping	Macular Degeneration	Burning eyes
Dry eyes	Red eyes	Glaucoma	Flashes / Floaters	Discharge from eyes
Excessive tears	swollen	Cataracts	Double vision	Itchy eyes
Explain:				
Professional Notes:				

HEARING:

Hearing Loss	High Pitched Tinnitus	Clogged Ears	Vertigo
Ear Pain	Low Pitched Tinnitus	Drainage	Other:
Explain:			
Professional Notes:			

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SKIN

<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	Skin ulcers	<input type="checkbox"/>	
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Acne	<input type="checkbox"/>	itching	<input type="checkbox"/>	
<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	Prickly heat	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	Oily skin
If so, where?							
Professional Notes:							

PERSPIRATION (check those that apply)

<input type="checkbox"/>	Too easily	<input type="checkbox"/>	Frequent sweating	<input type="checkbox"/>	Feet Sweating
<input type="checkbox"/>	Too little	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	Absence of Sweating
<input type="checkbox"/>	Profuse sweating	<input type="checkbox"/>	Palms Sweating	<input type="checkbox"/>	Other
Describe:					
Professional Notes:					

TEMPERATURE (Check those that apply):

<input type="checkbox"/>	Feel cold easily	<input type="checkbox"/>	Alternating hot and cold	<input type="checkbox"/>	Cold weather bothers you
<input type="checkbox"/>	Feel hot easily	<input type="checkbox"/>	Experience hot flashes	<input type="checkbox"/>	Hot weather bothers you
<input type="checkbox"/>	Cold Hands	<input type="checkbox"/>	Sensitive to weather changes	<input type="checkbox"/>	Damp weather bothers you
<input type="checkbox"/>	Cold feet	<input type="checkbox"/>	Sensitive to barometric change	<input type="checkbox"/>	Windy weather bothers you
Describe:					
Professional Notes:					

SLEEP:

<input type="checkbox"/>	Wake refreshed	<input type="checkbox"/>	Awakened by pain	<input type="checkbox"/>	palpitations
<input type="checkbox"/>	Difficulty falling asleep	<input type="checkbox"/>	Sudden awakening	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	Difficulty in falling back asleep	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Can't stop thinking
<input type="checkbox"/>	Awakened easily	<input type="checkbox"/>	Susceptibility to fear & fright	<input type="checkbox"/>	Restlessness
<input type="checkbox"/>	Difficulty waking	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Drowsiness during the day
<input type="checkbox"/>	Early morning waking	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	# of hours of sleep/night
<input type="checkbox"/>	Dream Disturbed sleep	<input type="checkbox"/>	Worry		
<input type="checkbox"/>	Unwanted movements	<input type="checkbox"/>	Poor memory		
Explain:					
Professional Notes:					

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REPRODUCTIVE (Women only)

Age of first Menses:	Are you still having regular monthly menstrual periods?				
If no, when & why did it stop?					
Are you now or have you ever taken the birth control pill?	If so, when?				
Have you ever had a miscarriage?	If yes, how many Miscarriages, and when?				
Do you regularly have the cancer test of the cervix?	Date of last test:				
How many children born alive?	How many cesarean operations?				
Explain any complications of pregnancy:					
Do you have recurring yeast infections?					
How many days per cycle?	How many days does it last?		Is your cycle regular?		
Is color of flow...	Pale red?	Dark red?	Bright red?	Purplish?	
Do you ever have clots?	If yes, are color of clots...	Pale red?	Dark red?	Bright red?	Purplish?
Is amount of flow...	Very light?	Light?	Normal?	Heavy?	Very heavy?
Is Quality of flow...	Thin?		Normal?		Thick?
Do you have bleeding between your periods?			If yes, how often and amount:		
Do you have any type of pain?		Before flow?		During flow?	After flow?
Is the pain located in the ...		Head?	Chest?	Abdomen?	
		Side of chest?	Breasts?	Lower back?	
Is the pain relieved by...		Heat?	Cold?	Pressure?	
Is the pain aggravated by...		Heat?	Cold?	Pressure?	
Is the pain...		Dull?		Sharp and stabbing?	
		A burning sensation?		A "bearing down" sensation?	
Emotions around period...		Depression?		Irritability?	
Anger?		Sadness?		Crying?	
Do these emotions come...	Before flow?		During flow?		After flow?
Professional Notes					

REPRODUCTIVE (Men only)

Have you ever had Loss of sexual function?	If yes, for how long?		
Treatment for genitals?	Hernia (rupture)?	Prostate Disease?	
Professional Notes:			

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ENERGY

<input type="checkbox"/>	Low	<input type="checkbox"/>	Exhausted	<input type="checkbox"/>	Nervous energy	<input type="checkbox"/>	Changes in memory
<input type="checkbox"/>	Up & Down	<input type="checkbox"/>	Hyperactive	<input type="checkbox"/>	Abundant	<input type="checkbox"/>	Normal

Libido: Low? Average? High?

Explain

Professional Notes:

EMOTIONS

<input type="checkbox"/>	Depression	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Worry	<input type="checkbox"/>	Angry	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	Sadness	<input type="checkbox"/>	Sensitive	<input type="checkbox"/>	Overly Excited	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Memory Problems

Explain:

Professional Notes:

Do you frequently have any of the following:

<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	Spells of Dizziness	<input type="checkbox"/>	Weakness of arms or legs
<input type="checkbox"/>	Halitosis (bad breath)	<input type="checkbox"/>	A sore tongue	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Hair loss
<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Edema/ swelling	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	Mouth Sores	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Explain:

Professional Notes: