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New Patient Health History Questionnaire

Please help in providing you with the best care by taking time to fill out this questionnaire. *All of your answers will be held absolutely confidential*. If you have any questions, please ask. Please use the backside of any of these sheets if you need more space or if any problems that you would like to discuss that are not included in this form.

Welcome!

First Name:	Last Name:	Male/Female
Address:		
City:	State:	Zip:
Phone(s):		
Email:		
Date of birth:	Age:	
Marital status:	Occupation:	
Emergency contact:	Relationship:	Phone:
How did you hear about Catherine Provencal L.Ac.?		
Have you ever been treated with acupuncture before?		

Please describe your goals and / or health concerns for your visit today:

_____

_____

When did these those health concerns begin?

_____

_____

To what extent does the problem(s) interfere with your daily activities (work, sleep, recreation, etc.)?

_____

_____

Have you been given a diagnosis for this problem? If so, what?

_____

What other types of treatment have you tried?

_____

Please list some of the major stressors in your life:

_____

Medical History

Allergies (drugs, foods, chemical/environmental):

_____

_____

Medications/ supplements/ vitamins (in the last two months):

_____

_____

Past medical history (including childhood illnesses):

_____

_____

Surgeries/ procedures (and dates):

_____

_____

Significant injuries/ trauma (auto accidents, falls, etc.):

_____

_____

Significant diagnoses: Please indicate if you have any of the following:

- ❑ Autoimmune condition [type]:_____
- ❑ Bleeding disorder / Blood thinners
- ❑ Believe you are or may be pregnant
- ❑ Cancer [type(s) and date(s)]:_____
- ❑ Cardiac pacemaker
- ❑ Chemical dependency (alcohol, drugs)
- ❑ Depression / other mental illness
- ❑ Diabetes
- ❑ Fainting disorders
- ❑ Heart disease
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV/AIDS positive
- ❑ Kidney diseases
- ❑ Lyme disease
- ❑ Neurological disease (multiple sclerosis, Parkinson's dz, etc.)
- ❑ Seizure disorder
- ❑ Sexually transmitted diseases
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Stroke
- ❑ Other:_____

Family Medical History: Have any members of your family, (including grandparents, parents, siblings, and children), had any of the following:

Problem	Circle Yes or No		Family Relationship
Alcoholism / Substance Abuse	Y	N	
Allergies	Y	N	
ALS (Lou Gehrig's Disease)	Y	N	
Asthma	Y	N	
Alzheimer's Disease	Y	N	
Anemia / Bleeding Problems	Y	N	
Cancer (Breast, Ovarian, Colon, Other)	Y	N	
Depression / Other Mental Illness	Y	N	
Diabetes	Y	N	
Heart Disease / Angina	Y	N	
Hepatitis / Liver Disease	Y	N	
High Blood Pressure	Y	N	
High Cholesterol	Y	N	
Kidney Disease	Y	N	
Osteoporosis	Y	N	
Seizure Disorders	Y	N	
Stroke	Y	N	
Thyroid Disease	Y	N	
Tuberculosis	Y	N	
Other (please describe):	Y	N	

Lifestyle

Activity	Frequency (per week)
Exercise program (what kind):	
Tobacco smoking	
Alcohol drinking	
Water (fluids) intake (not including caffeinated drinks)	
Caffeinated beverages (coffee, tea, cola)	
How much sugar/dessert do you eat?	
How much dairy do you eat?	
Recreational drugs	

How many hours do you sleep per night?

_____

Please describe your average daily diet (morning, afternoon, evening, snacks); Are you on a restricted diet?

_____

_____

_____

PATIENT MEDICAL SYMPTOMS

Please check any symptoms you have had in the past three to six months:

General

□ Fatigue
□ Feverish in the afternoon or flushes
□ Heat sensation in hands, feet, chest
□ Night sweats
□ Catch colds easily
□ Sweats easily during daytime
□ Feeling hot/fevers
□ Feeling cold/chills
□ Cravings
□ Change in appetite
□ Weight loss
□ Weight gain
□ Peculiar tastes or smells
□ Sudden drop in energy
□ General feeling of heaviness in the body
□ Energy drop after eating
□ Poor sleep/insomnia
□ Mental heaviness or fogginess

Skin & Hair

□ Rashes/hives
□ Itching
□ Dandruff
□ Change in hair or skin texture
□ Ulcerations/ unhealed sores
□ Loss of hair
□ Bruise easily
□ Warts
□ Pimples
□ Recent moles
□ Other hair or skin problems?_____

Head, eyes, ears, nose and throat

□ Glasses/ contacts
□ Poor vision
□ Cataracts
□ Eye strain/ pain
□ Dry eyes
□ Color blindness
□ Night blindness
□ Blurry vision
□ Spots/floaters
□ Sensation of something stuck in the throat
□ Poor hearing
□ Ear aches/ pain
□ Dizziness
□ Ringing in ears
□ Grinding teeth
□ Gum or teeth problems
□ Sore on lips, gums, tongue
□ Bitter taste in the mouth
□ Recurrent sore throat
□ Sneezing
□ Sinus problems
□ Nose bleeds
□ Facial pain
□ Jaw clicks/ locks
□ Concussions
□ Migraines
□ Headaches (where, when)?
□ Other head or neck problems?_____

Respiratory

□ Bronchitis
□ Pneumonia
□ Cough
□ Coughing blood
□ Production of phlegm (loose/thick/sticky/color?)
□ Asthma
□ Difficulty inhaling/exhaling
□ Wheezing
□ Shortness of breath
□ Chronic infections
□ Pain with a deep breath
□ Pulmonary embolism
□ Difficult breathing when lying down
□ Other lung/breathing problems? _____

Cardiovascular

□ Chest pain
□ Irregular heart beat
□ High blood pressure
□ Low blood pressure
□ Fainting
□ Colds hands or feets
□ Swelling of feet/ legs
□ Swelling of hands
□ Blood clots
□ Phlebitis
□ Varicose/ spider veins
□ Peripheral artery disease
□ Other heart or blood vessel problems?_____

Urinary

□ Frequent urination
□ Urgent urination
□ Unable to hold urine
□ Pain on urination
□ Blood in the urine
□ Decrease in urine flow
□ Kidney stones

□ Falling (prolapsed) bladder
□ Wake up to urinate (how often?)
□ Urine color (light or clear, amber, cloudy?)
□ Any other problems with your urinary system?_____

Gastrointestinal
□ Bad breath
□ Bleeding gums
□ Nausea
□ Vomiting
□ Indigestion/ acid reflux
□ Gall stones
□ Abdominal pain or cramps
□ Gas
□ Bloating
□ Belching
□ Diarrhea/ loose stools
□ Alternating diarrhea with constipation
□ Undigested food in stool
□ Constipation
□ Burning sensation after eating
□ Blood in stools
□ Rectal pain
□ Hemorrhoids
□ Incomplete bowel movements
□ Any other stomach or intestinal problems?_____

Neurological
□ Seizures
□ Stroke
□ Concussion
□ Dizziness
□ Loss of balance
□ Lack of coordination
□ Areas of numbness
□ Poor memory
□ Tremors (where?)_____
□ Any other neurological problems?
_____

Emotional/ Mental
□ Depression
□ Anxiety
□ Panic attacks
□ Poor concentration
□ Easily angered
□ Easily susceptible to stress
□ Easily over worried
□ Seasonal affective disorder
□ ADD/ ADHD
□ Bipolar disorder
□ Post-traumatic stress disorder (PTSD)

Have you ever been treated for emotional problems?
_____
Have you ever considered or attempted suicide?
_____
Any other psychological problems?
_____

Female reproductive
Are you pregnant now? LMP: _____
□ Yes □ No
Number of children: _____
Number of pregnancies: _____
Age of first period: _____
Age of menopause if applicable: _____
Is your menses cycle regular?
□ Yes □ No
Average number of days in flow:____
The flow is:
□ Normal □ Heavy □ Light
The color is:
□ red □ dark □ purple
□ light brown □ brown
Do you have the following menstruation related symptoms?
□ Blood clots
□ Cramps
□ Nausea
□ Breast distension
□ PMS
□ Bleeding between periods
□ Heavy vaginal discharge between periods
Other:
□ Infertility
□ Western fertility treatments
□ Breast lumps
□ Sexually transmitted disease
□ Sores on genitals
Birth control (how long & what type):
_____
Libido (sex drive) is:
□ Normal □ Low □ High

Men reproductive
□ Discharge
□ Pain or swelling of testicles
□ Ejaculatory problems
□ Impotence/erectile dysfunction
□ Prostatitis
□ Enlarged prostate
□ Prostate cancer
□ Sores on genitals
□ Low sperm count
Libido (sex drive) is:
□ Normal □ Low □ High

Musculoskeletal

Do you currently have pain anywhere in your body? (Yes or No): _____

How long? _____

If yes, please indicate location(s) on the diagram below.

Please rate severity on scale of 1-10 (with 10 as highest): _____

Check applicable boxes:
□ Arthritis
□ Joint pain/swelling
□ Stiffness
□ Weakness
□ Numbness/Tingling
□ Osteoporosis
□ Muscle spasms/cramps
□ Sciatica
□ Hernia
□ Any other muscle, joint or bone pain? _____

The information on pages 1-6 is true to the best of my knowledge.

Signed: _____ **Date:** _____