Compassionate Dragon Acupuncture, LLC

Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Date:

Last Name	First Name	Middle Initial	Male/Female	Date of Birth	Marital Status	Are you pregnant?

Street Address	Home Phone	Work Phone

City	State	Zip	Cell Phone	E-mail

Occupation	Employer	Have you had acupuncture? Y N Referred by:

Primary Physician	Last date MD consulted	Emergency contact name	Emergency contact phone number

What is your present complaint/concern?

_____

_____

_____

Significant Past Illnesses

☐ Cancer	☐ Diabetes	☐ HIV+	☐ Heart Disease	☐ Fibromyalgia
☐ Thyroid Disease	☐ Seizures	☐ CFS/EBS	☐ Epilepsy	☐ Hepatitis
☐ Rheumatic Fever	☐ Chicken Pox	☐ Stroke	☐ Measles	☐ Hypoglycemia
☐ High Blood Pressure	☐ Meniere's	☐ Mumps	☐ Mono	☐ Polio

Other Illnesses: _____

Surgeries (include procedure and date)

_____

_____

Significant Traumas (include auto accidents, falls, broken bones, etc.)

_____

_____

Family Medical History

Please indicate **M**other, **F**ather, **S**ister, or **B**rother

☐ Diabetes M F S B	☐ Alcoholism M F S B	☐ Seizures M F S B
☐ Asthma M F S B	☐ Mental Illness M F S B	☐ Emphysema M F S B
☐ Arthritis M F S B	☐ Stroke M F S B	☐ High Blood Pressure M F S B
☐ Allergies M F S B	☐ Obesity M F S B	☐ Other _____ M F S B
☐ Heart Disease M F S B	☐ Thyroid Problems M F S B	

Habits - Please indicate amount and frequency of use.

☐ Cigarettes	☐ Tea	☐ Drugs	☐ Sugar	☐ Other _____
☐ Coffee	☐ Cola	☐ Alcohol	☐ Salt	

Average Daily Food Intake

What do you actually eat? Morning _____

Height: _____ Midday _____

Weight: _____ Evening _____

Physical Symptoms

Please check all symptoms you have experienced during the past 6 months. Circle those that have been the most troublesome.

General

- ☐ Poor Endurance
- ☐ Sleep (Avg ___ hrs)
- ☐ Insomnia
- ☐ Wakens easily
- ☐ Unable to fall asleep
- ☐ Heavy Sleep
- ☐ Unable to stay asleep
- ☐ Dream disturbed sleep
- ☐ Nightmares
- ☐ Localized weakness
- ☐ Awaken fatigued
- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Gnawing hunger
- ☐ Food cravings
- ☐ Peculiar tastes/smells
- ☐ Change in appetite
- ☐ Obesity
- ☐ Recent weight loss/gain
- ☐ Tire easily
- ☐ Fevers
- ☐ Chills
- ☐ Cold back
- ☐ Cold abdomen
- ☐ Sweat easily
- ☐ Excessive sweating
- ☐ Lack of perspiration
- ☐ Night sweats
- ☐ Sudden energy drop @___time
- ☐ Fatigue
- ☐ Vertigo
- ☐ Chills easily
- ☐ Low fever, late afternoon or evening
- ☐ Blood transfusion
- ☐ Cold hands/feet
- ☐ Poor coordination
- ☐ Jaundice
- ☐ Anemia
- ☐ Tremors
- ☐ Aversion to talking
- ☐ Strong thirst cold/hot drinks
- ☐ Bleed or bruise easily (where? _____)
- ☐ Cuts bleed excessively
- ☐ Takes afternoon rests/naps
- ☐ Most energized in the am
- ☐ Most energized in the pm
- ☐ Prolonged recovery following illness

Overall energy level: ☐very high ☐ high ☐ medium ☐ low ☐ very low

_____

_____

_____

Skin & Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Ulcerations
- ☐ Psoriasis
- ☐ Fingernail problems
- ☐ Hair/skin changes
- ☐ Pimples/boils
- ☐ Purpura
- ☐ Warts/growths
- ☐ Hives
- ☐ Boils
- ☐ Dandruff
- ☐ Itching
- ☐ Fungal infections
- ☐ Loss of hair
- ☐ Cracks
- ☐ Shingles
- ☐ Dry hair/skin
- ☐ Brittle hair
- ☐ Limp hair
- ☐ Painful scars
- ☐ Lumps or bumps
- ☐ Pasty/pale complexion
- ☐ Other hair/skin problems

_____

_____

Head

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
  When? _____
  Where? _____
- ☐ Headaches
- ☐ Paralysis
- ☐ Eye strain
- ☐ Color blindness
- ☐ Eye pain/itch
- ☐ Cataracts
- ☐ Spots in eyes/floaters
- ☐ Eyes watering
- ☐ Double vision
- ☐ Blurry vision
- ☐ Dry eyes
- ☐ Poor vision
- ☐ Night blindness
- ☐ Glaucoma (pressure in eyes)
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Frequent head colds
- ☐ Earaches
- ☐ Loss of balance
- ☐ Mucus
- ☐ Ear drainage
- ☐ Hoarse voice
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Facial pain
- ☐ Mouth/lip sores
- ☐ Jaw clicks
- ☐ Sinus infections
- ☐ Sneezing spells
- ☐ Teeth problems
- ☐ Loss of teeth
- ☐ Teeth hurt
- ☐ Sore/bleeding gums
- ☐ Bad taste in mouth
- ☐ Dry throat
- ☐ Dry mouth
- ☐ Loose teeth
- ☐ Bad breath
- ☐ Difficulty swallowing
- ☐ Nasal congestion
- ☐ Glasses
- ☐ Recurrent sore throat
- ☐ Grinds teeth
- ☐ Sore tongue
- ☐ Facial pain/tics
- ☐ Excess saliva
- ☐ Stuffy/runny nose
- ☐ Nose bleeds
- ☐ Sinus pressure
- ☐ Sinus congestion
- ☐ Post nasal drip

_____

_____

_____

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest pain/pressure
- ☐ Rapid heart beat
- ☐ Blood clots
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Fainting
- ☐ High cholesterol
- ☐ Vascular spiders
- ☐ Leg cramps
- ☐ Swelling in hands/feet
- ☐ Varicose veins
- ☐ Blood disorder
- ☐ Raynaud's disease
- ☐ Skipped heartbeats
- ☐ Phlebitis (inflamed veins)
- ☐ Mitral valve prolapse

Respiratory

- ☐ Cough
- ☐ Shortness of breath
- ☐ Coughing blood
- ☐ Asthma
- ☐ TB
- ☐ Tight chest
- ☐ Wheezing or gasping
- ☐ Dry cough
- ☐ Bronchitis
- ☐ Seasonal allergies
- ☐ Frequent colds
- ☐ Emphysema
- ☐ Excessive phlegm
- ☐ Whooping cough
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ How many pillows used? ___

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Belching
- ☐ Food sits in stomach
- ☐ Bitter taste in mouth
- ☐ Ulcer
- ☐ Hiatal hernia
- ☐ IBS
- ☐ Acid reflux
- ☐ Indigestion
- ☐ Bad breath
- ☐ Constipation
- ☐ Diarrhea/loose stool
- ☐ Sweet taste in mouth
- ☐ Gall bladder problems
- ☐ Liver problems
- ☐ Colitis
- ☐ Stomachache
- ☐ Pain/cramps
- ☐ Rectal pain/itch
- ☐ Bloody stools
- ☐ Black stools
- ☐ Intestinal gurgling
- ☐ Colon problems
- ☐ ST problems
- ☐ Bowel frequency
- ☐ Hemorrhoids
- ☐ Number of daily BMs ___
- ☐ Recent weight loss/gain
- ☐ Laxative use
- ☐ Fecal incontinence
- ☐ Bloating
- ☐ Parasites

Genitourinary

- ☐ Burning/pain with urination
- ☐ Unable to hold urine
- ☐ Wake up to urinate
- ☐ Frequent urination
- ☐ Weakened urine stream
- ☐ Cloudy urine
- ☐ Kidney stones
- ☐ Dribble urine with sneeze
- ☐ Difficulty or slow starting stream
- ☐ Kidney infections
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ VD
- ☐ Herpes
- ☐ Flank pain
- ☐ Urgency to urinate
- ☐ Painful sex
- ☐ Change in sexual energy
- ☐ Infertility
- ☐ Bedwetting

Women

- ☐ Vaginal burning/itching
- ☐ Vaginal discharge
- ☐ Yeast
- ☐ Vaginal sores
- ☐ Itch
- ☐ Vaginal bleeding between periods
- ☐ Number of pregnancies
- ☐ Endometriosis
- ☐ Change in flow
- ☐ Ovarian cysts
- ☐ Vaginal infections
- ☐ Last menstrual period
- ☐ Number of births
- ☐ Premature births
- ☐ Miscarriages
- ☐ Age of first menses
- ☐ Duration of periods
- ☐ Last Pap
- ☐ Last mammogram
- ☐ Fibroids
- ☐ Water retention
- ☐ Abortions
- ☐ Sexually active
- ☐ Irregular menses
- ☐ Clots
- ☐ Painful menses
- ☐ Birth control
- ☐ Now pregnant
- ☐ Breast lumps
- ☐ Breast tenderness/pain
- ☐ Breast discharge
- ☐ Hysterectomy
- ☐ Menopausal
- ☐ Other surgeries
- ☐ Sexual drive increased
- ☐ Sexual drive depressed
- ☐ PMS
- ☐ Change in body/psych prior to menstruation
- ☐ Hot flashes
- ☐ HRT
- ☐ PID
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Children (names/ages)

Describe your usual flow or current stage of pregnancy

Men

- ☐ Testicular pain
- ☐ Penile pain
- ☐ Genital itch
- ☐ Sexually active
- ☐ Prostate enlargement
- ☐ Hernia
- ☐ Loss of erection, impotence
- ☐ Nocturnal emissions
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Prostatitis
- ☐ Loss of semen during the day
- ☐ Premature ejaculation
- ☐ Syphilis
- ☐ Sexual drive increased
- ☐ Sexual drive depressed
- ☐ Children (names/ages)

_____

_____

Musculoskeletal

- ☐ Muscle pain
- ☐ Muscle spasms, cramps, tension
- ☐ Swollen joints
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Osteoporosis
- ☐ Fractures/broken bones
- ☐ Arthritis
- ☐ Leg cramps
- ☐ Bone pain
- ☐ Neck pain
- ☐ Gout
- ☐ Joints make noise
- ☐ Joint replacement
- ☐ Whiplash
- ☐ Pain down legs
- ☐ Bone problems
- ☐ Trembling, tremors
- ☐ Back pain
  - ○ Upper
  - ○ Mid
  - ○ Lower
- ☐ Numbness, tingling
- ☐ Disc problems
- ☐ Intermittent pain
- ☐ Constant pain
- ☐ Weak muscles
- ☐ Other spinal problems

	No pain		Mildly Annoying		Nagging, uncomfortable		Distressing, miserable		Intense, horrible		Worst possible, unbearable
Current level of pain	0	1	2	3	4	5	6	7	8	9	10

Are you physically active on a regular basis? yes / no Type of exercise: _____ How long: _____ How often: _____

_____

_____

Neuro/Emotional/Psychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Worry a lot
- ☐ Depression
- ☐ Anxious/nervous
- ☐ Feel overwhelmed
- ☐ Poor memory
- ☐ Unusual fears
- ☐ Forgetful
- ☐ Agitation
- ☐ Decisions difficult
- ☐ Lose temper easily
- ☐ Easily stressed
- ☐ Feel unhappy
- ☐ Work/family problems
- ☐ Poor concentration
- ☐ Fatigue
- ☐ Considered suicide
- ☐ Attempted suicide
- ☐ Treated for emotional problems
- ☐ Repeated thoughts
- ☐ Disorientation
- ☐ Mood swings
- ☐ Drug addiction
- ☐ Inability to focus on tasks
- ☐ Hold a grudge
- ☐ Fearful
- ☐ Hyperactivity
- ☐ Dull thinking
- ☐ Stroke
- ☐ Paralysis
- ☐ Pessimistic
- ☐ Optimistic
- ☐ Perfectionist
- ☐ Motivation low
- ☐ Motivation normal
- ☐ Motivation high

What is your dominant emotion? _____ Describe your major life stresses: _____

_____

How do you deal with emotions? Stuff them/explode? Express them as they occur?

_____

Stress level: ☐very high ☐ high ☐ medium ☐ low ☐ very low

5-Phase Classical

Favorite Season_____

Favorite Taste_____

Favorite Climate _____

Favorite Time of Day_____

Favorite Temperature_____

Favorite Color _____

Life Assessment - Please rate each of the following areas of your life on a scale of 1 to 10, with 10 being very satisfying and fulfilling.

	1 2 3 4 5 6 7 8 9 10
Career	I__I__I__I__I__I__I__I__I__I
Job	I__I__I__I__I__I__I__I__I__I
Family	I__I__I__I__I__I__I__I__I__I
Personal Relationships	I__I__I__I__I__I__I__I__I__I
Social/Volunteer Relationships	I__I__I__I__I__I__I__I__I__I
Body and Health	I__I__I__I__I__I__I__I__I__I
Spiritual Growth	I__I__I__I__I__I__I__I__I__I
Leisure and Recreational	I__I__I__I__I__I__I__I__I__I
Educational	I__I__I__I__I__I__I__I__I__I

What do you do for fun? _____

How/when do you exercise? _____

Do you have a personal spiritual/meditation/prayer practice? _____

Do you have pets? yes / no Do you participate regularly in a faith-based group? yes no

Describe your marriage/relationship: _____

Describe your current living situation: _____

Describe any additional concerns you would like addressed during treatment: _____

_____

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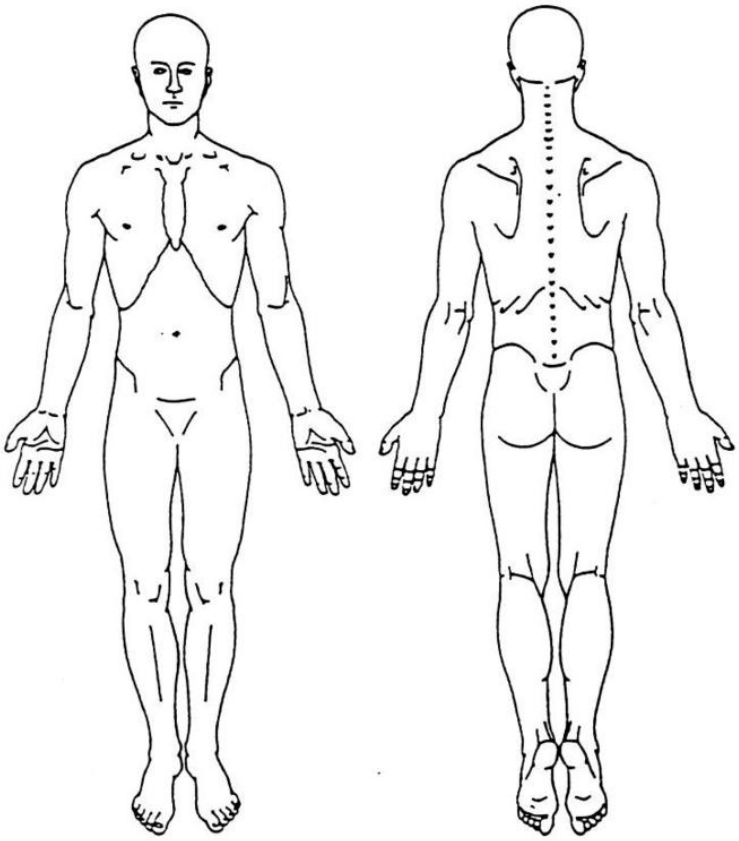
Pain Assessment Diagram

Circle or mark area of pain on the body diagrams below. *Please be as specific as possible*. For each area of pain, please include a description of what the pain feels like (sharp, stabbing, dull, consistent, intermittent, numbness, tingling, etc.) and how long you have had the pain.



If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____
_____
_____
_____
_____

List all medicines, herbs, remedies, and vitamins/supplements used in the last 2 months.

Medicine/herb/supplement Name	Dose	Frequency

List all Doctors and Therapists you have seen in the last 2 years.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
8. _____

How did you hear about us? _____

Would you like to receive email communications from us? _____