Durango Community Acupuncture

128 West 14th Street, Suite A2
Durango, CO 81301

www.DurangoCommunityAcupuncture.com

970.247.8838

Carla Marie Toth, LAc, MAOM
Julie Gwyther, LAc, MSOM

Acupuncture **Chinese Herbal Medicine** **Asian Bodywork**
Qi Gong **Reiki** **AromaTouch**

Welcome to **Durango Community Acupuncture** (DCA), **where your health is the point**. We are honored to serve you for your healthcare needs, and grateful that you have chosen to be a part of our community.

Below is a **Confidential Health History Questionnaire** that we ask you to fill out before your first visit. The questions are meant to give us a sense of your background and the patterns of well-being we can work to facilitate with you.

Our goal at DCA is to provide accessible Oriental Medicine for you, your friends and family. We are here **Monday through Friday, by appointment**. We look forward to this journey of health and wellness with you.

PRINTED NAME PHONE NUMBER (with area code) EMAIL ADDRESS*

*Please provide your email address only if you wish to be included on our newsletter/mailing list.

Health History Questionnaire

Information for your Acupuncturist

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Date: _____/_____/_____ Name: _____

Address: _____

City: _____ State: ___ Zip: _____

Home Phone: (_____) _____Cell Phone: (_____) _____ Email:_____

Age: _____ Date of Birth: _____/_____/_____ Place of Birth: _____

Guardian (if under 18): _____

Gender: ❑ M ❑ F Height: ____ ft. _____ in. Weight: _____ lbs.

(complete if using Insurance)

Social Security Number:_____- _____ - _____

Driver's Licence # (and State): _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: ___ Zip: _____

Does anything limit you from care? ❑ Y ❑ N If yes, explain: _____

How did you hear about our office? _____

Other physicians / therapists seen for this condition: _____

Medications (if any): _____

Prescribed by: _____

Treatment:

_____

_____

_____

Results:

_____

_____

_____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	Please describe:
1.	❑	❑	❑	❑	_____
2.	❑	❑	❑	❑	_____
3.	❑	❑	❑	❑	_____
4.	❑	❑	❑	❑	_____
5.	❑	❑	❑	❑	_____

How do these conditions impair your daily activities? _____

_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital visits/stays: _____

Recent tests: (please indicate test results and date below)

❑ Physical ❑ Cholesterol ❑ Prostate ❑ Blood (which?)

❑ HIV/STD ❑ Pap smear ❑ Mammography ❑ Other:_____

Test Results and Date: _____

_____

Check any you have had in the past:

❑ Diabetes ❑ Allergies ❑ Vein condition ❑ Thyroid disorder

❑ Heart Disease ❑ CVA (stroke) ❑ Tuberculosis ❑ Emphysema

❑ Asthma ❑ Pneumonia ❑ Mumps ❑ Bleeding tendency

❑ Jaundice ❑ Gonorrhea ❑ Chicken pox ❑ Nervous disorder

❑ Syphilis ❑ Measles ❑ Polio ❑ Mononucleosis

❑ Meningitis ❑ HIV ❑ Hepatitis ❑ Multiple Sclerosis

❑ Epilepsy ❑ High fever ❑ Migraines ❑ High blood pressure

❑ Paralysis ❑ Cancer ❑ Other heart illnesses ❑ Other kidney illnesses

❑ Other lung illnesses ❑ Other liver illnesses ❑ Other stomach illnesses ❑ Other:_____

❑ Other spleen illnesses ❑ Glaucoma ❑ Rheumatic Fever _____

Immunizations: _____

Surgeries: _____

III. Patient Profile

Use the diagrams to clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

❑ Sharp ❑ Burning ❑ Moving
❑ Cramping ❑ Dull ❑ Other:
❑ Fixed ❑ Aching

_____

Do the following lessen the pain?

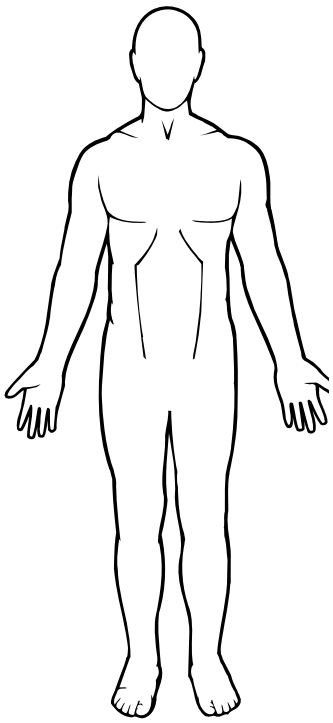
❑ Pressure ❑ Cold ❑ Other:
❑ Exercise ❑ Heat

_____

Do the following worsen the pain?

❑ Pressure ❑ Heat ❑ Other:
❑ Cold ❑ Exercise

_____



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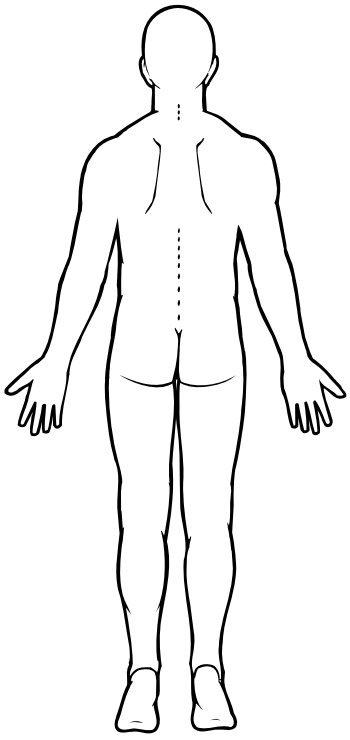

Back

Please check the following that pertain to you:

Overall Temperature (Kidney function):

❑ Cold hands
❑ Cold feet
❑ Sweaty hands
❑ Sweaty feet
❑ Hot body temperature (sensation)
❑ Cold body temperature (sensation)
❑ Afternoon flushes
❑ Night sweats
❑ Heat in the hands, feet and chest
❑ Hot flashes any time of the day
❑ Thirsty
❑ Perspire easily
❑ Lack of perspiration
❑ Take water to bed
❑ Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney function):

❑ Shortness of breath
❑ Difficulty keeping eyes open in the daytime
❑ General weakness
❑ Easily catch colds
❑ Low energy
❑ Feel worse after exercise

Blood (Liver, Spleen, Heart function):

❑ Dizziness

❑ See floating black spots

Heart function:

❑ Palpitations

❑ Anxiety

❑ Sores on the tip of the tongue

❑ Restlessness

❑ Mental confusion

❑ Chest pain traveling to shoulder

❑ Frequent dreams

❑ Wake un-refreshed

❑ Drink coffee (# of cups per week: _____)

Lung function:

❑ Nasal discharge (Color: _____)

❑ Cough

❑ Nose bleeds

❑ Sinus congestion

❑ Dry mouth

❑ Dry throat

❑ Dry nose

❑ Dry skin

❑ Allergies (To what? _____)

❑ Alternating fever and chills

❑ Sneezing

❑ Headache (Location: _____)

❑ Overall achy feeling in the body

❑ Stiff neck

❑ Stiff shoulders

❑ Sore throat

❑ Difficulty breathing

❑ Smoke cigarettes (# of cigarettes per day: _____)

❑ Sadness

❑ Melancholy

Spleen function:

❑ Low appetite

❑ Abrupt weight gain

❑ Abrupt weight loss

❑ Abdominal bloating

❑ Abdominal gas

❑ Gurgling noise in the stomach

❑ Fatigue after eating

❑ Prolapsed organs (previously diagnosed, which organ? _____)

❑ Easily bruised

❑ Hemorrhoids

❑ Pensive

❑ Over-thinking

❑ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

❑ Loose

❑ Constipated

❑ Incomplete

❑ Diarrhea

❑ Blood in stools

❑ Mucous in stools

❑ Undigested food in stools

Dampness trapped in the body:

❑ General sensation of heaviness in the body

❑ Mental heaviness

❑ Mental sluggishness

❑ Mental fogginess

❑ Swollen hands

❑ Swollen feet

❑ Swollen joints

❑ Chest congestion

❑ Nausea

❑ Snoring

Stomach functions:

- ❑ Burning sensation after eating
- ❑ Large appetite
- ❑ Bad breath
- ❑ Mouth (canker) sores
- ❑ Bleeding, swollen or painful gums
- ❑ Heartburn
- ❑ Acid regurgitation
- ❑ Ulcer (diagnosed)
- ❑ Belching
- ❑ Hiccoughs
- ❑ Stomach pain
- ❑ Vomiting

Liver, Gall Bladder function:

- ❑ Alternating diarrhea and constipation
- ❑ Chest pain
- ❑ Tight sensation in the chest
- ❑ Bitter taste in the mouth
- ❑ Anger easily
- ❑ Frustration
- ❑ Depression
- ❑ Irritability
- ❑ Frequently unable to adapt to stress (what causes the stress? _____)
- ❑ Skin rashes
- ❑ Headache at the top of the head
- ❑ Tingling sensation
- ❑ Numbness
- ❑ Muscle spasms
- ❑ Muscle twitching
- ❑ Muscle cramping
- ❑ Seizures
- ❑ Convulsions
- ❑ Lump in the throat
- ❑ Neck tension
- ❑ Limited Range-of-motion, Neck
- ❑ Shoulder tension
- ❑ Limited range-of-motion, shoulder
- ❑ Drink alcohol
- ❑ Recreational drugs (Which? _____, How much per week? _____)
- ❑ High-pitched ringing in the ears
- ❑ Gall stones (history of, or currently experiencing)
- ❑ Sexually transmitted disease (Which? _____)

Eyes (Liver function):

- ❑ Itchy
- ❑ Bloodshot
- ❑ Hot
- ❑ Dry
- ❑ Watery
- ❑ Gritty
- ❑ Blurry vision
- ❑ Decreased night vision
- ❑ Near-sighted
- ❑ Far-sighted

Kidney, Urinary Bladder function:

- ❑ Frequent cavities
- ❑ Easily broken bones
- ❑ Sore knees
- ❑ Weak knees
- ❑ Cold sensation in the knees
- ❑ Low back pain
- ❑ Memory problems
- ❑ Excessive hair loss
- ❑ Low-pitched ringing in the ears
- ❑ Kidney stones
- ❑ Bladder infections
- ❑ Wake during the night twice or more to urinate
- ❑ Lack of bladder control
- ❑ Fear
- ❑ Easily startled

Urination:

❑ Normal color
❑ Dark yellow
❑ Clear
❑ Reddish
❑ Cloudy
❑ Scanty
❑ Profuse
❑ Strong odor
❑ Burning
❑ Painful
❑ Discharge
❑ Difficult
❑ Urgent
❑ Frequent

Libido:

❑ Normal ❑ High ❑ Low

Other symptoms: _____

Women only:

Regular menstrual cycle? ❑ Y ❑ N
Number of children: _____
Age of first menstruation: _____
Average number of days of flow: _____
Average number of days of entire cycle: _____
Pregnant? ❑ Y ❑ N
Number of pregnancies: _____
Age of menopause (if applicable): _____

	Severe	Moderate	Slight	Normal
Vaginal discharge:	❑	❑	❑	❑
Bleeding between periods:	❑	❑	❑	❑

Do you experience any of the following premenstrual syndromes?

❑ Nausea
❑ Headaches
❑ Anxiety
❑ Food cravings
❑ Irritability
❑ Breast swelling
❑ Depression
❑ Water retention
❑ Breast tenderness
❑ Vomiting
❑ Migraines
❑ Dull pain? Where? _____
❑ Sharp pain? Where? _____
❑ Other emotions: _____
❑ Other: _____ _____

Please fill in the following menstrual chart: (put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain / cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

	Severe	Moderate	Slight	Normal
Swollen testes	❑	❑	❑	❑
Testicular pain	❑	❑	❑	❑
Impotence	❑	❑	❑	❑
Premature ejaculation	❑	❑	❑	❑
Feeling of coldness or numbness in external genitalia	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑

Any other Comments: _____

_____

_____

_____

_____

_____

Medication Log / Supplements (if any vitamins, herbs, minerals, etc.)

Name: _____ Date: _____

Medication	Dosage	Condition Taken For

IV. Family History

Family Member	Alive	Deceased	Present health or cause of death
Father	❑	❑	_____
Mother	❑	❑	_____
Spouse	❑	❑	_____
Children	❑	❑	_____
Brother	❑	❑	_____
Brother	❑	❑	_____
Brother	❑	❑	_____
Sister	❑	❑	_____
Sister	❑	❑	_____
Sister	❑	❑	_____

Where are you in the birth order? ❑ First ❑ Last ❑ Middle ❑ Only

Check the following that have occurred in your blood relatives:

❑ Diabetes ❑ Cancer ❑ Obesity ❑ Mental illness
❑ Allergies ❑ Tuberculosis ❑ Nervous illness ❑ Other: _____
❑ Kidney disease ❑ Alcoholism ❑ High blood pressure _____
❑ Stroke ❑ Heart disease ❑ Bleeding tendency

IV. Family Health History (cont'd)

Name: _____ Date: _____

Condition	Father	Mother	Brother	Sister	Child	Child	Child
Current Age:							
Arthritis							
Asthma							
Hay Fever							
Back Trouble							
Bursitis							
Constipation							
Diabetes							
Neck Pain							
Joint Pain							
Emotional Problems							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
Insomnia							
High Blood Pressure							
Kidney Trouble							
Liver Trouble							
Migraine							
Nervousness							
Pinched Nerve							
Stomach Trouble							
Other							

If any of the above family members are deceased, please list their age at death and cause: _____

_____

_____