SOJOURN ACUPUNCTURE
Community Wellness Center
New Patient Information/Personal Health History Form

Welcome to our clinic! This is a **CONFIDENTIAL questionnaire** to help us determine the best treatment plan for you. Your personal information will not be shared. If you have questions, please ask for clarification.

PLEASE PRINT

Name____Date_____________________
Home Address:City, State, Zip____
Age_______ Gender:_____________ Height _______ Weight_______ Date of Birth____________________
Place of Birth_________________________________ Occupation____________________________
Phone: Home________________________Cell________________________ Other____________________
Email____Emergency Contact___________________________
Phone#_____________________________ Relationship_____________________
Have you tried Acupuncture or Chinese Herbal Medicine before? __Yes __No If yes, When?_______________
For What?___________________________#of Treatments?____Results?_____________________________
How did you find about us?____

Main Complaints

Please write in your 3 complaints/concerns for which you are seeking treatment with Acupuncture.

Complaint	When did it start?	Rate Intensity: 1= Minor 10= Worst	What makes it better/ worse? Eg:Rest, Activity, Heat, Cold, Other
1-			
2-			
3-			

How often is pain/discomfort present?____80-100%____51-80%____26-50%___25% or less of the time.
Does it interfere with your daily activities? 1- ___Yes ___NO 2- ___Yes ___NO 3- ___Yes ___NO
Have you seen a Medical Doctor for this problem? 1- __Yes ___NO 2- ___Yes ___NO 3- ___Yes ___NO
What was the diagnosis? 1______________________2______________________3______________________

Family Medical History

Please indicate any significant illness you or a blood relative(Grandparent, Parent or Sibling) have had:

Illness	You	Relative	Approx. Yr.	Illness	You	Relative	Approx. Yr.
Allergies	_____	_____	______	Auto Immune	_____	_____	______
Asthma	_____	_____	______	Hypertension	_____	_____	______
Anemia	_____	_____	______	Heart Disease	_____	_____	______
Cancer	_____	_____	______	Stroke	_____	_____	______
Diabetes	_____	_____	______	Infectious Disease	_____	_____	______
Hepatitis	_____	_____	______	Rheumatic Fever	_____	_____	______
HIV/AIDS	_____	_____	______	Substance Abuse	_____	_____	______
Thyroid Dz	_____	_____	______	Emotional Disorders	_____	_____	______

STD's: _____ Gonorrhea _____ HPV _____ Chlamydia _____ Herpes _____ Syphilis
Other Significant Illness/Dz:____

			Comments
Do you take blood thinners or similar meds?	_____Yes	_____No	________________________
Do you have a pacemaker?	_____Yes	_____No	________________________
Do you consume caffeine?	_____Yes	_____No	________________________
Do you drink alcoholic beverages?	_____Yes	_____No	________________________

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Do you use tobacco? ___Yes ___No ______________________________
Do you eat regular meals daily? ___Yes ___No ______________________________
Have you done regular exercises in the last 3 months? ___Yes ___No ______________________________
Have you had any surgery in the last 12 months? ___Yes ___No ______________________________

How would you rate your average daily diet? _____ Great _____ Good _____Needs improvement_____Poor
Current Physician's Name___________________________________ Phone_________________________

List any medications & supplements you are currently taking:(If more, ask desk for blank form)

Medication	Dosage	Purpose	Date Began	Date Last Seen by M.D.

GYN History

Age of 1st Period____ Are you pregnant? ___Yes ___No___Unsure #Pregnancies/Live Births_____/_____
#Abortions/Miscarriages____/____ Form of Birth Control__________________Length Used?______________
Age at Last Period(Menopause)_________ Age Changes Began_________
Date of Last: GYN Exam ____________ Pap Smear ____________ Mammogram ______________
Bone Density Scan _________________ Results: ____________________________________

Menses:
Length of Cycle________________# Days of flow_________Color of flow_____________Clots? __Yes __ No
Average # of (pads/tampons) used per day: 1st day____ 2nd day____ 3rd day____ 4th day____ 5th day____
Date of Last Period________________________
If Menstrual Pain: Location of pain: __Lower abdomen __Lower back __Legs Other____________________
Nature of the pain:(Indicate if before, during or after menses)

Pain	*Before*	*During*	*After*	*Pain*	*Before*	*During*	*After*
Cramping	____	____	____	Stabbing	____	____	____
Burning	____	____	____	Throbbing	____	____	____
Dull Ache	____	____	____	Radiating	____	____	____
Sharp	____	____	____	Twisting	____	____	____
Spasms	____	____	____	Gnawing	____	____	____

Other Symptoms Related to Menses: (*Check if applicable*)
____Anger ____Constipation ____Insomnia ____Hot Flashes ____Swollen/Tender Breasts
____Mood Swings ____Diarrhea ____Cravings ____Night Sweats ____Midcycle Spotting
____Headaches ____Nausea ____Appetite+/- ____Libido+/- ____Yeast Infections
____Fatigue ____Acne ____Wt Gain ____Vaginal Dryness ____Bloating

Have you been diagnosed with:
____ Fibroids ____ PID ____ Fibrocystic Breasts ____ Endometriosis ____ Ovarian Cysts
____ PCOS ____ Infertility ____ Other ____

For Men

Date of Last Prostate Exam_______________ PSA Results ________________________________
Digital Prostate Exam Results ____
Lab Results ____

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Symptom Survey: For Male and Female
Please check next to any condition you have experienced in the last **THREE months**: Leave Blank=Never Experience; **Check Mark (✓)** =sometimes experience; **Plus sign(+)**= frequent experience; **Circle options**

GENERAL

___Fatigue
___Restlessness
___Hyperactive
___Heavy Limbs
___Localized Weakness
___Thirst+/- Pref Temp_____
___Cravings
___Weight Gain/Loss
___Appetite + / -
___Sweat Easily
___Tremors
___Bleed/Bruise Easily
___Night Sweats
___Fever
___Chills
___Sudden Energy Loss
___Poor Balance

Sleep Difficulty:

___Falling
___Staying
___Returning
___Waking
___Restless
___Nightmares
___Excessive
___Not Rested on Waking
___Naps
Other:_________________

SKIN and HAIR

___Tend to be Hot - Cold
___Intolerance To Cold
___Catch Colds Easily
___Intolerance To Weather Change
___Sweat EZ or Excessively
___Rashes
___Non-Healing Sores
___Itching
___Hives/Whelts
___Psoriasis or Eczema
___Acne
___Dandruff
___Hair Loss
___Recent Moles
___Texture Changes
___Soft Or Brittle Nails
Other:_________________

MUSCULO-SKELETAL

___Jaw Pain/TMJ
___Neck Pain
___Shoulder Pain
___Arm Pain
___Hand/Wrist Pain
___Back Pain: Up - Mid - Low
___Hip Pain
___Thigh Pain
___Knee Pain
___Lower Leg Pain
___Ankle Pain
___Foot Pain
___Walking Problems
___Joint Pain______________
___Stiffness/Swelling________
___Arthritis
___Scoliosis
___Muscle Twitches or Spasms
Other:_________________

HEAD/EENT

___ Headaches
___Migraines
___Lightheaded
___Dizziness
___Clouded Thinking
___Difficulty Making Decisions
___Concussion History
___Visual Disturbances
___Watery or Teary
___Irritation:Dry, Itchy, Burning
___Blurry Vision
___Night/Color Blindness
___Cataracts
___Eye Strain/Pain
___Vision Loss
___Earaches/Pain
___Ear Ringing
___Discharge
___Pressure or Congestion
___Hearing Loss
___Sinus Problems
___Nasal Congestion
___Nose Bleeds
___Decreased Sense Of Smell
___Difficulty Swallowing
___Sore Throats
___Voice Loss
___Teeth Grinding
___Sore Lips/Tongue
___Facial Pain
___ Dental Problems
___Jaw Clicking
Other:______________

CARDIOVASCULAR

___High Cholesterol
___Chest Pain
___Chest Pressure/Tightness
___Palpitations
___Irregular Heartbeat
___Dizziness
___Blood Pressure: High/Low
___Fainting
___Cold Hands/Feet
___Swollen Hands/Feet
___Blood Clots
___Shortness of Breath
___Difficulty Breathing
Other:_________________

RESPIRATORY

___ Pain/Difficulty Breathing
___ Shortness of Breath
___ Wheeze
___ Cough
___Coughing Phlegm/Blood
___ Bronchitis
___Pneumonia

GASTROINTESTINAL

Related to Appetite:

___Increased/Decreased
___ Loss of Appetite
___ **Crave** : Sweets Salt Spicy Bitter Sour

Digestion:

___Abdominal Pain/Cramps
___ Nausea
___Vomiting
___Bad Breath
___Belching
___Indigestion
___Heaviness or Fullness
___Acid Reflux
___Gas

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GASTRO-INTEST(cont.)
Bowel Movements:
___Reg Laxative Use
___Pain Before-During-After
___Weakness Before-During-After
___Loose Stools or Diarrhea
___Constipation
___Alternating Diarrhea/Constipation
___Undigested Food
___Blood or Pus
___Rectal Dysfunction
___Hemorrhoids
Other:________________

NERVOUS SYSTEM
___EasilySusceptible to Stress
___Anxiety
___Depression
___Easily Angered/Agitated
___Tendency To Be Obsessive
___Easily Fearful/ Frightened
___Difficulty Concentrating
___Poor Memory
___Dizziness
___Loss of Balance
___Lack of Coordination
___Concussion History
___Seizure History
___Numbness or Tingling
___Abnormal Sensations
___Treatment@Emotional Problems
___Treatment@Neurological Problems
___Treatment@Psychological Problems
___Considered or Attempted Suicide
Other:________________________

GENITOURINARY
Related to Urination:
___Painful
___Frequency + / -
___Incomplete
___Urinary Retention
___Urgent
___Hesitant or Delayed
___Dribbling
___Weak or Split Stream
___Unable to Hold
___Leaking
___BL/Ki Sand or Stones
___Genital Sores
___Blood or Pus
___Frequent Infections
Times Wake to Urinate___
Other:
___Pain/Cold In Genital Area

MEN
___Sex Drive + / -
___Erectile Dysfunction
___Premature Ejaculation
___Impotence
___Testicular Swelling
Other:________________________

Please list any other health concerns you would like to discuss. Confidential: Please let us know if you are HIV positive of if you have Hepatitis, TB or any other communicable disease.