1000 N. 72nd St. Omaha, NE 68114

Phone or Text: 402-827-1355
Email: frontdesk@thirteenmoonsacupuncture.com

Confidential Health Questionnaire

GENERAL INFORMATION: Date: _____

Name: _____ Age: _____ Birth Date: _____
First Middle Last

Address: _____
City State Zip Code

Birthplace: _____ Birth Time: _____ (AM/PM)
City State Country If Known (circle one)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Occupation & Work activities: _____ Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Mom ☐ School ☐ Retired ☐ Unemployed ☐ Other_____

Living Situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parents/Siblings Number of Children: _____

Names and ages of those living with you: _____

_____

Pets: _____

Status: ☐Single ☐Married ☐Partner ☐Divorced ☐Widowed

Name of Partner/Spouse/Parent: _____ Occupation: _____

In case of emergency, notify: _____ Phone No. _____

Religious/Spiritual Preferences: _____

Educational Background: _____

How did you hear of this clinic: _____

Have you had acupuncture before? _____

Financial agreement
I claim full financial responsibility for services rendered for_____ and understand that payment is required in full at time of service.
PATIENT

_____ _____
Signature Relationship to patient

Reason for this appointment? _____

_____

_____

When did this issue begin? _____

Was there an event surrounding the issue (i.e. accident/event) _____

Have you been given a diagnosis? _____ If so, what?_____

What kinds of treatment have you tried? _____

Have they helped alleviate the condition/problem? _____

Are you currently receiving treatment? _____If so, please describe: _____

List any other problems/concerns: _____

_____

_____

_____

_____

ALLERGIES:

Drug allergies (penicillin, etc.) _____

Allergies to foods, pollens, etc: _____

MEDICAL STATUS

General Health: ☐Excellent ☐Good ☐Fair ☐ Poor Height_____ Weight _____

Current Medications (vitamins, prescriptions, herbal or otherwise):

Medication name	Date started	Date stopped	Dosage	# per day

Past Medication Use:

	Infancy	Childhood	Teens	Adulthood
Antibiotics				
Steroids				

Who is your primary care physician? _____ Phone: _____

Have you seen a physician for any reason in the past 3 months? Y or N For what?_____

Have you had blood work in the past 3 months? Y or N Was it Normal? Y or N

If abnormal please describe: _____

_____

List any other Health Care providers:_____

_____

MEDICAL HISTORY

Illnesses:_____

_____

Significant Trauma (i.e. Motor Vehicle Accidents, Falls, etc):_____

_____

Broken bones or dislocations:_____

_____

X-ray, MRI, CAT or Bone Scans (where and when) what was found?_____

_____

Do you have or have you ever had any infectious disease? Recurring infections? Y or N

Describe:_____

How many times each year do you have a Cold, Sinusitis, the Flu, Sore throat, Bronchitis?_____

How long do they usually last and are they severe?_____

What do you feel your weakest organ system is? (i.e. heart, kidney, liver, lungs etc)_____

_____

HOSPITALIZATIONS/OPERATIONS

Date Diagnosis Surgery Outcome

_____

_____

_____

_____

SYMPTOMS CHECKLIST:

Circle those you presently have (during the last few weeks). **Underline** those you've had previously.

GENERAL
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Imbalance
Seizures
Epilepsy
Sleeping Difficulties
Quality of Sleep____
Sleep____hrs/night
Feel run down
Fatigue
Hypoglycemic
Nervousness/Anxiety
Panic Attacks/Phobias
Depression
On Anti-Depressants
Mental Disorder
Alcohol Problems
Drug Problems
Diabetes
Neuralgia
Anemia
Cancer
Memory Loss
Scarlet Fever
Rheumatic Fever
Measles
Mumps
Chicken Pox
Weight Loss _____lbs
Weight Gain _____lbs
Other_____

EAR NOSE THROAT
Eye Strain/Pain
Failing Vision
Blurred Vision
Glaucoma
Sensitive to Light
Hearing Problems
Ear Ringing/Noises
Ear Discharge
Sinus Infection
Nose Bleeds
Nasal Obstruction
Nasal Drainage
Sore Throat
Hoarseness
Loss of Voice
Dental Decay
Mouth Sores
Gum Disease
Teeth Grinding
Jaw Pain
Frequent Colds
Thyroid Condition
Tonsillitis
Enlarged Glands
Hay Fever
Other_____

SKIN
Rashes
Skin Eruptions
Eczema
Itching
Bruise Easily
Dry Skin
Boils
Moles
Varicose Veins
Sensitive Skin
Hair Loss
Other_____

RESPIRATORY
Asthma
Allergies
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Pleurisy
Chronic Cough
Spitting Blood
Spitting Phlegm
Chest Pain
Difficult Breathing
Shortness of breath
Other_____

CARDIOVASCULAR
Rapid Heartbeat
Slow Heartbeat
Irregular Heartbeat
High blood pressure
Blood Clots
Low Blood Pressure
Pain over Heart
Pacemaker
Hardening of Arteries
Ankle Swelling
Poor Circulation
Stroke/TIA
Other_____

MUSCLE & JOINT
Stiff Neck
Back Pain
Gout
Swollen Joints
Painful Joints
Arthritis
Bursitis
Tendonitis
Muscle/Joint Weakness
Muscle spasms/cramps
Foot Trouble
Spinal Curvature
Osteoporosis
Other_____

GENITOURINARY
Frequent Urination
Night Urination ____times
Painful Urination
Blood in Urine
Pus in Urine
Kidney Infection or Stones
Bed-wetting
Inability to control urine
Prostate trouble
Hernia
Sexually transmitted disease
Sexual Dysfunction/Difficulty
Other _____

GASTROINTESTINAL
Trouble Swallowing
Bad breath
Indigestion/Heartburn
Nausea
Poor Appetite
Belching/Gas
Excessive Hunger
Cravings
Eating Disorder
Vomit Blood
Stomach Pain
Cramping Pain
Ulcers
Abdomen Distention
Constipation
Diarrhea
Colitis/IBS
Appendicitis
Hemorrhoids
Intestinal Worms
Parasites
Hepatitis
Liver Problems
Gallbladder Problems
Jaundice
Bad Body Odor
Other_____

Other than the health concerns you already have indicated which of the following would you additionally like our support (Check all that apply)

☐ Have more energy/vitality	☐ Slow down accelerated aging	☐ Be happier
☐ Sleep better	☐ Monitor my body's aging	☐ Be less depressed
☐ Be less tired after lunch	☐ Maintain a healthier life longer	☐ Not so many drugs
☐ Get less colds and flu	☐ Be stronger	☐ Be less moody
☐ Get rid of allergies	☐ Reduce body fat	☐ Think more clearly
☐ Have more sex drive	☐ Be more flexible	☐Improve my memory
☐ Reduce my risk of degenerative disease	☐ Improve my skin quality/ youthfulness	☐ Learn how to reduce stress

Habits

Water: Glasses per day of: Tap_____ Bottled_____ Filtered_____

Alcohol: Wine # of glasses /day or week_____ Beer # glasses/ day or week_____

Liquor: #of ounces day or week _____

Caffeine: Coffee - cups/day_____ Tea - cups/day_____

Soda with caffeine: #of cans/day_____ Soda without caffeine: #of cans/day_____

Chocolate or other sweets How much day/ week_____

Smoke cigarettes: #/day_____ Previously? _____ How much? _____ How long? _____

Other tobacco #/day _____ Previously? _____ How much? _____ How long? _____

Mood altering substance use (i.e. marijuana, cocaine- past and present)_____

_____

Exposed to second hand smoke or pollution? _____Previously? _____ How much? _____ How long? _____

Chemicals at work or hobbies?_____ Previously? _____ How much? _____ How long?_____

Exercise: Type_____ Frequency_____

Do you have your teeth cleaned regularly?_____ Do you floss your teeth regularly?_____

How many times a day/week do you have bowel movements:? _____times per day/week (circle one)

Are your bowel movements loose, hard, difficult to pass, strong smelling, accompanied by gas? (Please circle all that apply.)What is the typical color? Blackish, brown, clay, greenish. Ever bloody?

On a scale of 1-10 (10 highest) what number do you believe reflects your current level of stress? _____

Please list the 3 or more most significant stressful events in your life:

Please indicate those continuing to impact your life.

Dietary Preferences

Sample of day's menu:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drink:_____

Dietary Restrictions:_____

What allergies to foods, drugs or inhalants are you aware of and how do you react? _____

_____

Family History

Member	Living?	Age?	Major Diseases*?	Cause of Death and Age
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandma				
Maternal Grandpa				
Paternal Grandma				
Paternal Grandpa				

*Alcoholism, High Blood Pressure, Cancer, Diabetes, Heart Disease, Arthritis, Asthma, Allergies, Depression, Other Addiction, Other illness.

FOR MEN ONLY

Please check or explain if applicable:

☐ Reduced Sexual Desire _____

☐ Premature Ejaculation _____

☐ Seminal Emission _____

☐ Impotence _____

☐ Painful or Dribbling Urine _____

☐ Pain associated with Genitals _____

Other/Additional Comments: _____

_____

FOR WOMEN ONLY:

☐Irregular Periods ☐Painful Periods ☐PMS ☐Light Flow ☐Heavy Flow ☐Clots ☐Vaginal Discharge

☐Endometriosis ☐PCOS ☐Ovarian Cysts ☐Uterine Fibroids ☐ Pelvic Surgery

BREASTS: ☐Pain/Tenderness ☐Lumps ☐Cysts ☐Discharge ☐Fibroids

Date last period began:_____ Date Prior period began_____

Age of first menstrual cycle_____ Age/Date of last menstrual cycle_____

Uterus/ovaries still in tact?_____ If no, date removed and why: _____

_____

Have you reached menopause? _____ List any symptoms you are experiencing _____

Date of last Pap Smear/Pelvic Exam:_____ Pap Normal? Yes/No (circle one)

Have you ever had an abnormal Pap?_____ When?_____ Results _____Treatment_____

Are you sexually active?_____ Do you practice safe sex?_____ Current birth control method_____

Past birth control methods _____

Pregnancies _____Births _____Miscarriages _____ Abortions_____

Normally (not on pills) the number of days from the start of one period to the start of the next? _____

Number of days of flow: _____Amount of bleeding: _____ Amount of cramps: _____

Color of blood (i.e. bright red/purplish/dark red etc)_____ Clots? _____

Premenstrual symptoms: _____ Starting when? _____

Any current changes in your normal pattern? _____

Any bleeding between periods? _____ When? _____ Any unusual vaginal discharge or itching? _____

How long? _____ Past treatment? _____

Any sexual concerns to discuss? _____ Any past history of tubal infection?_____

Any past history of sexually transmitted diseases?_____

Other/Additional comments:_____

_____

_____

_____

_____

_____

PAIN ASSESSMENT:

Did your pain or symptoms come on gradually or suddenly?_____ Is it constant or comes and goes?_____

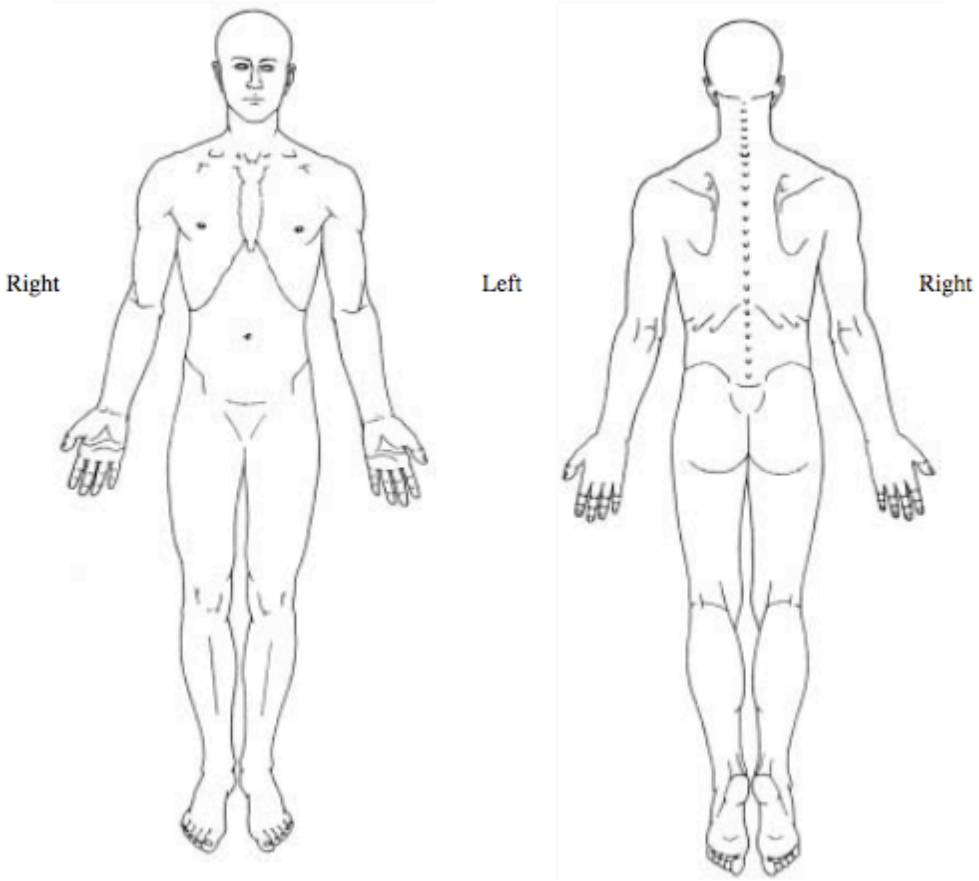
What time of the day is the pain the worst? Morning, Afternoon, Evening, Night, Constantly?_____

What makes the symptoms worst? _____

What makes your pain or symptoms better? _____

PATIENT PAIN DRAWING

Please place the symbol(s) on the body in the area(s)
that best describes the pain or discomfort you are having.



PP Sharp pain
DD Dull Pain
BB Burning
NN Numbness
TT Tingling
SS stabbing
AA Ache
Th Throbbing

On a scale of 0-10 with 0 being pain free and 10 being constant, disabling pain: Rate each area of pain.

Thank you ☺

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