HEALTH QUESTIONAIRE

NOTE: Please read carefully and fill out as completely as possible. The information provided will become a permanent part of your records at our office.

NAME____ **TODAY'S DATE**________________
LAST *FIRST* *MIDDLE*

DATE OF BIRTH ________________ **AGE** ________ **SSN (OPTIONAL)** ________________

ADDRESS ____
NUMBER *APT/SUITE#* *STREET* *CITY/STATE/ZIP*

PHONE (______) ___________ **WORK** (______) ___________ **MOBILE** (______) ___________

EMAIL ADDRESS ____

FEMALE ______ **MALE** ______ **APPROX HEIGHT** ______ (FT) **APPROX WEIGHT** _______(LBS)

MARITAL STATUS: SINGLE ______ **MARRIED** ______ **WIDOWED** ______ **DIVORCED** ______

EMPLOYER _______________________________ **OCCUPATION** ____________________

EMERGENCY CONTACT _______________ **RELATIONSHIP**___________ **PHONE** (____) _________

HOW DID YOU HEAR ABOUT US? ____

NAME AND ADDRESS OF YOUR FAMILY PHYSICIAN __________________________________

____

MAJOR COMPLAINTS AND HOW LONG HAVE THEY BEEN PRESENT?

____

____

____

IN YOUR OWN WORDS DESCRIBE YOUR MOST PERSISTANT MEDICAL PROBLEM INCLUDING SYMPTOMS, DURATION AND RESPONSE TO PREVIOUS TREATMENTS.

____

____

WHAT DO YOU EXPECT FROM YOUR TREATMENT? __________________________________

____

ILLNESS AND MEDICAL PROBLEMS (103)

Check problems you have or have had that have been diagnosed or treated by a physician or other health professional.

	YES	NO	PROBLEM
1.			Acne
2.			Alcoholism
3.			Allergies
4.			Anemia - Sickle Cell
5.			Anemia - Other
6.			Appendicitis
7.			Arthritis, degenerative or Osteoarthritis
8.			Asthma
9.			Back Strain
10.			Bladder infection - Cystitis
11.			Bronchitis - chronic
12.			Cancer - Breast
13.			Cancer - Cervix
14.			Cancer - Colon
15.			Cancer - Lung
16.			Cancer - Uterus
17.			Cancer - Prostate
18.			Cancer - Other
19.			Cirrhosis, Liver
20.			Colitis, spastic or ulcerative
21.			Concussion
22.			Congenital defect
23.			Depression
24.			Diabetes
25.			Diabetes, uncontrolled
26.			Emphysema
27.			Epilepsy
28.			Glasses or contacts
29.			Visual problem not correctable
30.			Astigmatism
31.			Nearsighted
32.			Farsighted
33.			Blindness, either eye
34.			Cataract, either eye
35.			Amblyopia, lazy eye
36.			Glaucoma
37.			Retinal detachment
38.			Fibrocystic breasts
39.			Gonorrhea
40.			Gout
41.			Hay fever
42.			Hearing loss left ear
43.			Hearing loss right ear
44.			High blood fats (check one) ☐ Cholesterol ☐ Triglycerides
45.			Heart Attack
46.			Coronary Disease
47.			Rheumatic Heart Disease
48.			Heart Valve Problem
49.			Heart Murmur
50.			Enlarged Heart
51.			Heart rhythm problem
52.			Other Heart problem (List) a) ______ b) ______
53.			Hemorrhoids
54.			Hepatitis
55.			Herpes (fever blisters, shingles, genital)
56.			Hiatal hernia
57.			High blood pressure
58.			High blood pressure, uncontrolled
59.			Hypoglycemia - low blood sugar
60.			Infectious mononucleosis
61.			Kidney infection - pyelonephritis
62.			Kidney problem - other
63.			Knee injury
64.			Mental illness
65.			Migraine headache
66.			Neck strain
67.			Nervous stomach
68.			Obesity - more than 20 lbs. overweight
69.			Ovarian cyst
70.			Pelvic infection
71.			Peptic Ulcer - gastric, duodenal
72.			Phlebitis
73.			Pneumonia
74.			Polyps in colon
75.			Prostate infection
76.			Regional ileitis
77.			Rheumatic fever
78.			Rheumatoid arthritis
79.			Sinus trouble, chronic
80.			Serious injury with permanent damage
81.			Stroke
82.			Suicide attempt
83.			Syphilis
84.			Thyroid overactive
85.			Thyroid underactive
86.			Tension headaches
87.			Tuberculosis
88.			Vaginitis, chronic
89.			Other problem not listed

DISABILITY (104)

A disability is a medical problem that causes long term impairment of your ability to work or function.

YES NO

1. ______ ______Do you have a medical DISABILITY?

If "YES" specify.

____

Specify needs, functional status for disability.

2. ______Wheelchair 3. ______Require special housing.

4. ______Use crutches 5. ______Sports activity restricted.

YES NO

6. ______ ______Do you have loss or seriously limited function of any of the organs listed below?

If "YES" specify.

7. ______EYES 8. ______BOWELS

9. ______ARMS OR LEGS 10. ______EARS

11. ______KIDNEYS 12. ______OTHER

ALLERGIES (105)

An allergy is a skin rash, hives, joint pain or swelling, or fever after exposure to a desensitizing agent.

YES NO

1. ______ ______Have you ever undergone Allergy Testing?
If "YES", when? ______

2. ______ ______Do you have any ALLERGIES? If "YES" check items to which you are allergic.

3. ______Aspirin
4. ______Bee Stings
5. ______Certain animals
6. ______Food Allergies
   a) ______
   b) ______
   c) ______
   d) ______
   e) ______
   f) ______
   g) ______
   h) ______
7. ______Dust
8. ______Eggs
9. ______Grasses
10. ______Molds, fungi
11. ______Penicillin
12. ______Poison Ivy
13 ______Pollens, ragweed
14. ______Sulfa
15. ______Tetanus Toxoid
16. ______X-Ray media
17. ______Drug Allergies
   a)______
   b)______
   c)______
   d)______
   e)______
   f)______
   g)______
   h)______

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MEDICATIONS (106)

YES NO

1. ______ ______Do you take any MEDICINE frequently or regularly?

Name and Dosage

2. ______Antacid ______
3. ______Antibiotic ______
4. ______Antidepressant ______
5. ______Antihistamines ______
6. ______Allergy shots ______
7. ______Arthritis medicine ______
8. ______Aspirin ______
9. ______Asthma medicine ______
10. ______Barbiturate ______
11. ______Blood Thinner ______
12. ______Blood Vessel dilator ______
13. ______Birth control pill ______
14. ______Coronary heart medicine ______
15. ______Cortisone steroid ______
16. ______Cough medicine ______
17. ______Diabetic pill ______
18. ______Diet pill ______
19. ______Digitalis ______
20. ______Diuretic ______
21. ______Epilepsy, seizure medicine ______
22. ______Estrogen-hormone ______

Name and Dosage

23. ______Headache medicine ______
24. ______Heart rhythm med. ______
25. ______High blood pressure med. ______
26. ______Insulin ______
27. ______Iron ______
28. ______Laxative ______
29. ______Muscle relaxant ______
30. ______Nasal spray ______
31. ______Nitroglycerin ______
32. ______Nerve medicine ______
33. ______Pain medicine ______
34. ______Penicillin ______
35. ______Potassium Supplement ______
36. ______Rheumatic heart med. ______
37. ______Sleeping pills ______
38. ______Stomach medicine ______
39. ______Sulfa ______
40. ______Tetracycline ______
41. ______Thyroid hormone ______
42. ______Tranquilizer ______
43. ______Vitamin Supplements ______
   a) ______ g) ______
   b) ______ h) ______
   c) ______ i) ______
   d) ______ j) ______
   e) ______ k) ______
   f) ______ l) ______

HOSPITALIZATIONS (107)

YES NO

1. _______ _______ Have you had any HOSPITALIZATIONS?

	Reason	Name of Doctor	Year
a)			
b)			
c)			
d)			
e)			
f)			
g)			

OPERATIONS

YES NO

2. _______ _______ Have you had any OPERATIONS?
If "YES" check and date organs of operation.

	Mo.	Yr.		Mo.	Yr.
3. __Appendix			18. __Hysterectomy		
4. __Back			19. __Joint		
5. __Bone			20. __Kidney		
6. __Brain			21. __Lung		
7. __Breast			22. __Neck		
8. __Colon			23. __Nose		
9. __C-Section			24. __Ovary		
10. __Cystoscopy			25. __Prostate		
11. __D and C			26. __Spleen		
12. __Ears			27. __Stomach		
13. __Eyes			28. __Testicle		
14. __Gallbladder			29. __Thyroid		
15. __Heart			30. __Tonsils		
16. __Hemorrhoids			31. __Tubal ligation		
17. __Hernia			32. __Other		

33. **SPECIALIST RECOMMENDED BY YOUR FAMILY M.D.**

Drs. Name & Specialty ____________________

Specialist Diagnosis ____________________

Specialist Recommendations ____________________

____

____

Did You Comply with Recommendations? ____________________

____

FAMILY MEDICAL HISTORY (BLOOD RELATIVES) (108)

Check items that apply for your **blood relatives.** Your blood relatives include your children, brothers, sisters, parents, and grandparents.

1. _______ Do not know my family medical history.

	YES	NO	ILLNESS	RELATIONSHIP
2.			Alcoholism	
3.			Anemia-sickle cell	
4.			Anemia - other	
5.			Bleeding Trait	
6.			Cancer	
7.			Diabetes	
8.			Epilepsy	
9.			Heart Disease	
10.			High Blood Pressure	
11.			Hyperlipidemia High Blood Fats	
12.			Mental Illness	
13.			Obesity	
14.			Peptic Ulcer	
15.			Polycystic Kidney	
16.			Rheumatoid Arthritis	
17.			Stroke	
18.			Suicide	
19.			Thyroid overactive	
20.			Thyroid underactive	
21.			Tuberculosis	
22.			Ulcerative colitis	
23.			Other	

Check the items that apply.

24. _____ _____ Are you a twin?
25. _____ _____ Father died of heart attack before age of 60?
26. _____ _____ Mother died of heart attack before age of 60?
27. _____ _____ Brother or sister died of heart attack before age of 60?
28. _____ _____ Mother or sister had cancer of the breast?
29. _____ _____ Did your mother take DES when she was pregnant with you?

INTERVIEWERS COMMENTS: (126)

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REVIEW OF SYSTEMS: THESE ITEMS CONCERN EITHER EXISTING CONDITIONS OR SYMPTOMS THAT OCCURRED **WITHIN THE PAST YEAR.** THEY REPRESENT THE DETAIL THAT HEALTH PROFESSIONALS SEEK IN EVALUATING A PERSON'S CURRENT OR POTENTIAL HEALTH PROBLEMS. DO NOT FILL IN LINES AT BOTTOM OF SECTION.

HEAD (109)

YES NO In the past year, have you had—

1. _____ _____Staggering or balance problems?
2. _____ _____Lightheadedness on standing up?
3. _____ _____Spinning sensation or dizziness?
4. _____ _____Fainting spells/Blackout spells?
5. _____ _____Convulsions or seizures?
6. _____ _____Muscular twitching?
7. _____ _____Memory problem?
8. _____ _____Difficulty with coordination?
9. _____ _____Numbness or tingling in arms or legs?
10. _____ _____Popping sensation when opening mouth?
11. _____ _____Frequent or severe headaches?
12. _____ _____Head injury or concussion requiring hospitalization?

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EYES (110)

YES NO In the past year, have you had—

1. _____ _____Persistent pain in either eye?
2. _____ _____Puffiness or dark circles under eyes?
3. _____ _____Persistent watering or itching eyes?
4. _____ _____Red, sore eyelids?
5. _____ _____Double vision?
6. _____ _____Problem of seeing halos around lights?
7. _____ _____Blurry Vision?
8. _____ _____Sensitivity to lights?
9. _____ _____Partial or full loss of vision?
10. _____ _____Cataract or Cataract Surgery?
11. _____ _____Glaucoma?
12. ___________Date of last eye examination

____

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EARS, NOSE, AND THROAT (111)

YES NO In the past year, have you had—

1. _____ _____Hearing difficulties or loss of hearing?
2. _____ _____Buzzing or Ringing in ears?
3. _____ _____Frequent earaches?
4. _____ _____Sinus trouble with stuffy nose, headache?
5. _____ _____Frequent postnasal drip, tickle in throat?
6. _____ _____Nosebleeds not due to injury?
7. _____ _____Frequent sore throats?
8. _____ _____Persistent or frequent hoarseness?
9. _____ _____Persistent sore tongue?
10. _____ _____Bleeding or sore gums?
11. _____ _____Decreased sense of taste or smell?
12. _____ _____Swollen Glands in neck?

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RESPIRATORY (112)

YES NO In the past year, have you had—

1. _____ _____Frequent or persistent wheezing?
2. _____ _____Frequent or persistent cough?
3. _____ _____Frequent or severe SHORTNESS OF BREATH?

If "YES" for shortness of breath, describe.

4. _____Present for years
5. _____Began recently
6. _____Worse with exercise
7. _____Present at rest
8. _____Relieved by resting
9. _____Occurs with chest pains
10. _____Occurs with wheezing
11. _____Occurs with coughing
12. _____Interferes with work or daily activities

YES NO

13. _____ _____Recurrent Bronchitis?
14. _____ _____Pneumonia?
15. _____ _____Do You Smoke?
16. _____ _____Have you ever coughed up blood?
17. ___________Date of last chest x-ray
18. _____ _____Positive or reactive T.B. test?

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CARDIOVASCULAR (113)

YES NO In the past year, have you had—

1. _____ _____Shortness of breath when lying down?
2. _____ _____Using more than one pillow to sleep?
3. _____ _____Fluid retention with swelling of feet or legs?
4. _____ _____Episodic pain, whiteness of hands or feet?
5. _____ _____Calf pain when walking, relieved by rest?
6. _____ _____Irregular heartbeat, skipped beats?
7. _____ _____Bouts of heartbeat so fast you can't count?
8. _____ _____Pain, pressure, or tight feeling in chest which forced you to stop walking?
9. _____ _____Frequent or severe CHEST PAIN?

If "YES" for chest pain, describe.

10. _____Present at rest
11. _____Worse with exercise
12. _____Worse with deep breathing
13. _____Worse with nervousness
14. _____Relieved by resting
15. _____Relieved with Nitroglycerin
16. _____Relieved with Antacids
17. _____Dull ache, pressure
18. _____Sharp, knife-like
19. _____Behind breastbone
20. _____Radiates to arms
21. _____Chest is sore to touch
22. _____Heart murmur
23. _______________Date of last visit with Cardiologist
24. _______________Date of last electrocardiogram

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DIGESTIVE (114)

YES NO In the past year, have you had—

1. ______ ______Frequent nausea or vomiting?
2. ______ ______Vomiting of bright red blood?
3. ______ ______Vomiting of "Coffee Grounds" material?
4. ______ ______Difficulty swallowing?
5. ______ ______Hot burning fluid in throat or chest?
6. ______ ______Black tarry stools?
7. ______ ______Frequent diarrhea or watery stools?
8. ______ ______Frequent constipation?
9. ______ ______Unexplained rectal bleeding?
10. ______ ______Frequent or severe heartburn or indigestion?
11. ______ ______Frequent or severe ABDOMINAL PAIN?

If "YES" for abdominal pain, describe.

12. ______Upper abdomen
13. ______Lower abdomen
14. ______Right side
15. ______Left side
16. ______Dull ache
17. ______Cramping
18. ______Sharp, knife-like
19. ______Burning

Abdominal pain accompanied by—

20. ______Constipation
21. ______Diarrhea
22. ______Nausea
23. ______Menstrual periods

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URINARY (115)

YES NO In the past year, have you had—

1. ______ ______Loss of Urine control?
2. ______ ______Awaken from sleep to urinate frequently?
3. ______ ______Urinate more than 10 times a day?
4. ______ ______Frequent pain or burning with urination?
5. ______ ______Blood in urine?
6. ______ ______Pain in flank accompanied by fever?
7. ______ ______Abdominal pain with urination?
8. ______ ______Trouble getting urine started?
9. ______ ______Bedwetting problems?

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MEN (WOMEN GO TO NEXT SECTION) (116)

YES NO In the past year, have you had—

1. ______ ______Enlarged or infected prostate?
2. ______ ______Pus or drainage from penis?
3. ______ ______Rupture or swelling in groin?
4. ______ ______Nodule in testicle growing larger?
5. ______ ______Problem with sexual function?
6. ______ ______Pain or tenderness in groin?

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WOMEN (MEN GO TO PREVIOUS SECTION) (117)

YES NO Have you ever—

1. ______ ______Had a period? 2. ________Date of last period
3. ______ ______Age of onset of period?
4. ______ ______Been pregnant?

If answer to #4 is "YES"

5. __________# of pregnancies
6. __________# of live births
7. ______________________________ weights of live births
8. __________# of miscarriages
9. __________complications of pregnancies

____

YES NO

10. ______ ______Been on Birth Control Pills?
11. ______ ______Had hard lumps or cysts in breasts?
12. ______ ______Do you have routine annual breast exams?
13. ______ ______Excessive pain, bleeding with periods?
14. ______ ______Irregular periods?
15. ____________Date of last Pelvic and Pap Smear.
16. ______ ______Bleeding or spotting between periods?
17. ______ ______Vaginal bleeding after menopause?
18. ____________Age at time of Menopause?
19. ______ ______Persistent Vaginal itching or dryness?
20. ______ ______Treatment for Vaginal Infection or discharge?
21. ______ ______Problem with Sexual dysfunction?

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MUSCULOSKELETAL (118)

YES NO In the past year, have you had—

1. ______ ______Frequent or severe neck, back pain?
2. ______ ______Muscle weakness or fatigue?
3. ______ ______Pain or stiffness in joints?
4. ______ ______Muscle or tendon problems due to sports?
5. ______ ______Persistent JOINT PAIN NOT due to injury?

If "YES" for joint pain NOT due to injury, describe:

Accompanied by—

6. ______Swelling
7. ______Hot feeling
8. ______Redness
9. ______Stiffness
10. ______Painful feet

____

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NEUROLOGICAL (119)

YES NO In the past year, have you had—

1. ______ ______Numbness?
2. ______ ______Convulsions or seizures?
3. ______ ______Trembling episodes?
4. ______ ______Periods of unconsciousness?
5. ______ ______Stroke?
6. ______ ______Loss of feeling or sensation over any part of your body?

____

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VASCULAR (120)

YES NO In the past year, have you had—

1. _____ _____Varicose Veins?
2. _____ _____Phlebitis?
3. _____ _____Easy Bruising?
4. _____ _____Easy Bleeding?
5. _____ _____Ulcers on lower extremities?
6. _____ _____Cold, numb or tingling extremities?
7. _____ _____Leg or calf cramps at night?
8. _____ _____Coronary Artery Disease?

____

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SKIN (121)

YES NO In the past year, have you had—

1. _____ _____Itching or burning skin?
2. _____ _____Discolored moles or warts?
3. _____ _____Loss of large amounts of hair?
4. _____ _____Skin lesions/skin cancers?
5. _____ _____Dry skin or brittle nails?
6. _____ _____Scaling of skin of lower extremities?
7. _____ _____Discoloration of skin?
8. _____ _____Skin or whites of eyes turning yellow?
9. _____ _____Persistent rash or pimples?
10. _____ _____Eczema, Psoriasis?

____

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ENDOCRINE (122)

YES NO In the past year, have you had—

1. _____ _____Weight gain or loss?
2. _____ _____Frequent or constant thirst?
3. _____ _____Poor wound healing?
4. _____ _____Hypo (low) thyroidism?
5. _____ _____Hyper (high) thyroidism?
6. _____ _____Hot Flashes?
7. _____ _____Temperature Intolerances?
8. _____ _____Constant Fatigue?
9. _____ _____Congenital abnormalities?
10. _____ _____Sweating episodes at night?

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EMOTIONAL (123)

YES NO In the past year, have you had—

1. _____ _____Loneliness?
2. _____ _____Depression?
3. _____ _____Lack of concentration or memory?
4. _____ _____Crying Spells?
5. _____ _____Considered Suicide?
6. _____ _____Sleeping difficulties?
7. _____ _____Excessive nervousness?
8. _____ _____Still tired after full night's sleep?
9. _____ _____Difficulty relaxing?
10. _____ _____Psychological/Psychiatric Counseling?

____

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____

GENERAL (124)

YES NO In the past year, have you had—

1. _____ _____Pollen Allergies?
2. _____ _____Food Allergies?
3. _____ _____Drug Allergies?
4. _____ _____Reaction to drugs, serum or other medication?
5. _____ _____Frequent colds of flu like syndromes?

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CHILDREN ONLY (125)

THE FOLLOWING QUESTIONS PERTAIN SPECIFICALLY TO CHILDREN. THIS INFORMATION WILL HELP US TO ASCERTAIN AN OVERALL PICTURE OF THE CHILD'S MEDICAL PROBLEMS.

YES NO Does the child have—

1. _____ _____Chronic runny nose?
2. _____ _____Chronic red, itchy eyes?
3. _____ _____Purulent drainage from eyes or ears?
4. _____ _____Chronic sneezing spells?
5. _____ _____Recurrent episodes of areas of patchy, dry, scaly skin?
6. _____ _____Whining episodes?
7. _____ _____Sudden changes in temperment?
8. _____ _____Spells of intense temper with fury?
9. _____ _____Few friends?
10. _____ _____Problems being shy/timid?
11. _____ _____Crying spells without reason?
12. _____ _____Difficulty learning simple tasks?
13. _____ _____Writing problems?
14. _____ _____Reading problems?
15. _____ _____Speaking problems or stuttering?
16. _____ _____Problems in school?
17. _____ _____Disciplinary problems?
18. _____ _____Problems gaining weight?
19. _____ _____Finicky/picky eating habits?
20. _____ _____Periods of fatigue/lethargy?
21. _____ _____Nightsweats?
22. _____ _____Problems with bedwetting?
23. _____ _____Problems with bowel or urine incontinence?
24. _____ _____Problems with frequent diarrhea or constipation?
25. _____ _____Episodes of Hyperactivity?
26. _____ _____Sleeping problems/Nightmares?
27. _____ _____Problems with sluggishness in the morning?

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1. **HEALTH HISTORY:** Have you *ever* been diagnosed with any of the following health problems?

- ☐ Tension Headaches
- ☐ Migraine Headaches
- ☐ TMJ Disorder
- ☐ Back Pain or Sciatica
- ☐ Chest Pain or Angina Pain
- ☐ Abdominal Pain
- ☐ Pelvic or Genital Pain
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Bone Fracture or Joint Sprain
- ☐ Muscle Spasms or Tremors
- ☐ Carpal Tunnel Syndrome
- ☐ Tennis Elbow
- ☐ Frozen Shoulder
- ☐ Peripheral Neuropathy
- ☐ Shingles (Herpes Zoster)
- ☐ Skin Disorder, Eczema, Hives
- ☐ Reynaud's Disease
- ☐ Coronary Disorder or Heart Attack
- ☐ Lung or Respiratory Disorder
- ☐ Liver Disease or Hepatitis
- ☐ Urinary or Bladder Infection
- ☐ Kidney Disorder or Kidney Stones
- ☐ Gall Bladder Disorder or Gall Stones
- ☐ Spleen or Lymphatic Disorder
- ☐ Gastric or Peptic Ulcer
- ☐ Irritable Bowel Syndrome or Colitis
- ☐ Diabetes Mellitus
- ☐ Hypoglycemia
- ☐ Thyroid Disorder
- ☐ Dysmenorrheal
- ☐ Pre-Menstrual Syndrome
- ☐ Prostate or Vaginal Disorder
- ☐ Deafness or Tinnitus
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Seizures or Epilepsy
- ☐ Concussion
- ☐ Cancer or Tumors
- ☐ HIV or Aids
- ☐ Multiple Sclerosis
- ☐ Polio or Mononucleosis
- ☐ Allergies or Hay fever
- ☐ Asthma or Bronchitis
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Attention Deficit Disorder
- ☐ Obsessive-Compulsive
- ☐ Panic Attacks or Phobias
- ☐ Major Depression
- ☐ Schizophrenia

2. **ACCIDENTS:** Have you *ever* been injured in any of the following types of accidents?

- ☐ Automobile Accident
- ☐ Athletic Injury
- ☐ Work-Related Accident
- ☐ Surgical Complication
- ☐ Accident at Home
- ☐ Other ____________________

3. **CURRENT CONDITIONS:** In the past year, have you experienced any of the following symptoms?

- ☐ Pain in Legs or Feet
- ☐ Pain in Arms, Wrist or Hands
- ☐ Cold Hands or Feet
- ☐ Swollen Ankles or Feet
- ☐ Stiff, Aching Joints
- ☐ Neck or Shoulder Tension
- ☐ Grinding your Teeth
- ☐ Rapid Heart Beats
- ☐ Excessive Sweating
- ☐ Hyperventilation
- ☐ Dizziness or Fainting
- ☐ Excessive Weight Gain or Weight Loss
- ☐ Overeating or Binge Eating
- ☐ Under eating or Poor Appetite
- ☐ Craving for Sweets
- ☐ Craving for Drugs or Alcohol
- ☐ Dissatisfaction with Job
- ☐ Boredom or Uninterested in Things
- ☐ Loneliness or Lack of Affection
- ☐ Sex Life not Satisfying
- ☐ Thoughts of Suicide
- ☐ Sinus Congestion
- ☐ Cold, Flue or Chills
- ☐ Sore Throats
- ☐ Nausea or Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blurred Vision
- ☐ Lethargy or Fatigue
- ☐ Difficulty Sleeping
- ☐ Disturbing Dreams
- ☐ Relationship Problems
- ☐ Worrying about Finances

4. **SUBSTANCES OR MEDICATIONS:** In the past year, did you take any of the following?

- ☐ Cigarettes or Cigars
- ☐ Coffee
- ☐ Beer or Wine
- ☐ Liquor or Mixed Drink
- ☐ Aspirin or Tylenol
- ☐ Prescription Pain Medication
- ☐ Recreational Drugs
- ☐ Cola
- ☐ Sleeping Pills
- ☐ Anti-Anxiety Pills
- ☐ Anti-Depressant Pills
- ☐ Blood Pressure Pills

MARK WHAT TRULY REPRESENTS YOUR HABITS:

	HEAVY	MODERATE	LIGHT	NONE
Chocolate	______	______	______	______
Tea	______	______	______	______
Coffee	______	______	______	______
Cola	______	______	______	______
Appetite	______	______	______	______
Exercise	______	______	______	______
Smoking	______	______	______	______
Alcohol	______	______	______	______
Drugs	______	______	______	______

The above information is true and complete to the best of my knowledge. I also release the therapist and any place or business occupied by such therapist from any injury that may be incurred due to not informing the therapist of any current or previous conditions. I also understand that it is my responsibility to inform my therapist of any changes or illnesses. ________ ***(Initials)***

I do hereby agree on this day to allow Dr. Weathers, OMD to use acupuncture needles, cupping and moxibustion (herbal heat) on me. I understand that a fee will be added to by bill for additional treatments. I also understand that acupuncture is not considered a cure for any ailment. ________ ***(Initials)***

I understand I will be charged **$50** for any appointments not cancelled with a 24-hour notice and payment of this cancellation fee is due on or before my next visit. ________ ***(Initials)***

I understand payment IN FULL is due when services are rendered. I also understand Dr. Weathers, OMD does not accept payments from any insurance company. A print out of services can be provided and I can file an insurance claim on my own. ________ ***(Initials)***

I understand my first visit, which includes consultation and treatment, will be **$250**. Follow up visits range from **$100** to **$150**. Packages are available. Please ask the doctor for more information. ________ ***(Initials)***

I understand Dr. Weathers, OMD does not accept check payments. Cash and Credit Card payments are acceptable. ________ ***(Initials)***

PARTY RESPONSIBLE FOR PAYMENT: ______________________ **PHONE** (______) ______________

ADDRESS ____
NUMBER *APT/SUITE#* *STREET* *CITY/STATE/ZIP*

PATIENT SIGNATURE ______________________________ **DATE** ______________

GUARDIAN SIGNATURE (If Patient under 18 years) ______________________________