



Alt Med Ctr L.L.C.
Alternative Medicine Center

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This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you.
Please fill it out as completely as possible. Thank you.

Personal Information

Name _____ Age _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ E-mail _____

Birthdate _____ If under 18, person responsible for your account _____

Emergency Contact: Name _____ Contact Phone: _____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? Yes No With Whom? _____

Have you had homeopathic treatment before? Yes No With Whom? _____

Please indicate if any of the following pertain to you: (marking “yes” does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

- Hepatitis HIV High Blood Pressure Seizures Pacemaker Blood-Thinning Meds Pregnancy

Give the following information for the last times you have been hospitalized starting with the most recent (except normal deliveries); include type of illness, month and year hospitalized, name of hospital, city and state.

#1: _____ #2: _____

#3: _____ #4: _____

Please indicate the use and frequency of the following:

Coffee _____ Soft Drinks _____ Water _____

Alcohol _____ Recreational drugs _____ Tobacco _____

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____



Health History

What are the health problems for which you are seeking treatment? _____

How long have you had this condition? _____

What other forms of treatment have you sought? _____

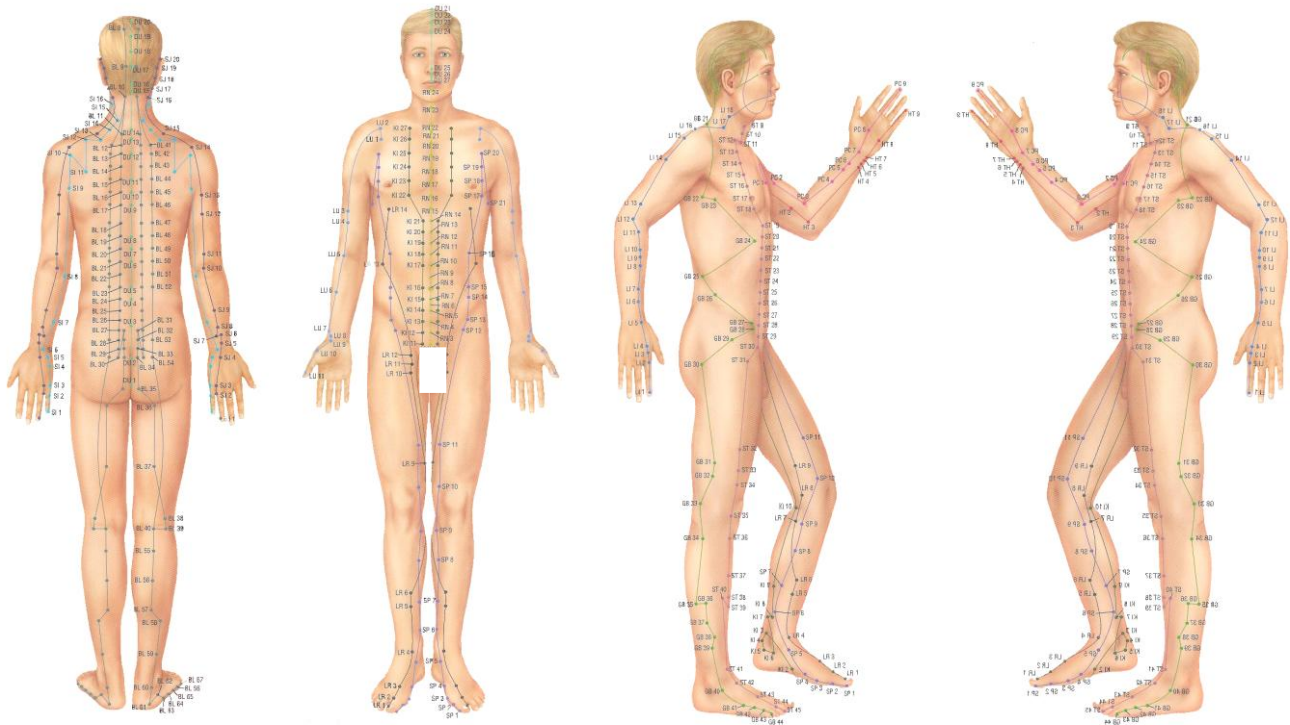
What helps your condition? _____

What aggravates your condition? _____

Please list any surgeries or major health incidents (accidents, etc.) in your life: _____

Additional Information: _____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain: dull/achy sharp/stabbing burning tingling numbness electrical

What would you like to achieve with treatment? _____



Symptom Survey

Please “check” the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> insomnia	<input type="checkbox"/> cough	<input type="checkbox"/> low back pain	<input type="checkbox"/> eye problems
<input type="checkbox"/> loose stool/diarrhea	<input type="checkbox"/> palpitations	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> knee problems	<input type="checkbox"/> jaundice
<input type="checkbox"/> digestive problems, indigestion	<input type="checkbox"/> cold hands and feet	<input type="checkbox"/> decreased sense of smell	<input type="checkbox"/> hearing impairment	<input type="checkbox"/> difficulty digesting oily foods
<input type="checkbox"/> vomiting	<input type="checkbox"/> nightmares	<input type="checkbox"/> nasal problems	<input type="checkbox"/> ear ringing	<input type="checkbox"/> gall stones
<input type="checkbox"/> belching, burping	<input type="checkbox"/> mentally restless	<input type="checkbox"/> skin problems	<input type="checkbox"/> kidney stones	<input type="checkbox"/> light-colored stool
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> laughing for no reason	<input type="checkbox"/> claustrophobia	<input type="checkbox"/> decreased sex drive	<input type="checkbox"/> soft/brittle nails
<input type="checkbox"/> stomach bloating	<input type="checkbox"/> chest pains	<input type="checkbox"/> colitis/diverticulitis	<input type="checkbox"/> hair loss	<input type="checkbox"/> easily angered
<input type="checkbox"/> obsession in work, relationships, etc.	<input type="checkbox"/> poor memory	<input type="checkbox"/> constipation	<input type="checkbox"/> urinary problems	<input type="checkbox"/> difficulty in making decisions
<input type="checkbox"/> lack of appetite	<input type="checkbox"/> sadness	<input type="checkbox"/> blood in stool	<input type="checkbox"/> easily bruised	<input type="checkbox"/> high cholesterol
<input type="checkbox"/> fatigue	<input type="checkbox"/> edema	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> dental problems	<input type="checkbox"/> dizziness
<input type="checkbox"/> get sick easily		<input type="checkbox"/> asthma		<input type="checkbox"/> headaches
<input type="checkbox"/> recent use of antibiotics		<input type="checkbox"/> allergies		<input type="checkbox"/> bitter taste
	<input type="checkbox"/> I usually feel warm	<input type="checkbox"/> I usually feel chilled		

♀ For Women

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow _____

Color of flow:

- pale/light red
- red
- bright red
- dark red
- dark red/brown

Amount of flow:

- spotting
- light
- even throughout
- heavy
- clots

of pads/tampons you use per day:

- 1st day ____
- 2ND day ____
- 3RD day ____
- 4th day ____
- +days ____

Pain and cramping:

- No
- Yes
 - before flow mild
 - during flow moderate
 - after flow severe

Other symptoms related to menses:

- Discharge PMS Headache Nausea Constipation Diarrhea
- Swollen Breasts Mood Swings Increased Appetite Decreased Appetite Insomnia

