***HEALTH QUESTIONNAIRE***

DATE:\_\_\_/\_\_\_\_\_/\_\_\_\_

NAME AGE BIRTHDATE SEX

ADDRESS STREET TOWN ZIPCODE

HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENTING PROBLEM:

HAVE YOU EVER BEEN EXAMINED BY ME BEFORE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT OR RECENT MD/DO/DC (CIRCLE ONE) NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIAGNOSIS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE PAIN? WHERE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT AGGRAVATES/ALLEVIATES YOUR PAIN?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW IS YOUR ENERGY?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DO YOU FEEL EMOTIONALLY?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST OF ALL ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SMOKE?\_\_\_\_\_\_\_\_\_\_\_IF SO? YEARS\_\_\_\_\_\_\_\_\_\_\_\_\_\_MONTHS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU DRINK ALCOHOL BEVERAGES?\_\_\_\_\_\_\_\_\_\_\_\_IF SO:DAY/WEEK\_\_\_\_\_\_\_\_\_MONTH\_\_\_\_\_\_\_

WHERE DO YOU HOLD TENSION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT DO YOU DO FOR RELAXATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE YOUR EATING HABITS:

|  |  |
| --- | --- |
| DIET/EATING HABIT | HOW MANY SERVINGS DAY OR WEEKLY |
| FRUIT |  |
| MEAT/FISH/FOWL |  |
| SUGAR/SWEETS |  |
| TEA/COFFEE CUPS OR MUGS |  |
| DIARY PRODUCTS |  |
| FLOUR PRODUCTS |  |
| VEGETABLES |  |
| SODA |  |
| WATER |  |
| WHOLE GRAINS |  |
|  |  |

HOW MUCH SLEEP DO YOU GET AT NIGHT?

HOURS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DIFFICULTY? (EXPLAIN)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT IS YOUR REGULAR FORM OF EXERCISE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THERE ANY SIGNIFICANT ABOUT YOUR BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL MEDICATIONS, SUPPLEMENTS, EYE DROPS, OVER THE COUNTER PRESCRIPTIONS, AND TOPICALS:

YOUR PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY)

|  |  |  |
| --- | --- | --- |
| MEASLES (VACCINE) | MUMPS (VACCINE) | WHOOPING COUGH |
| CHICKEN POX (VACCINE) | SCARLET FEVER | DIPHITHERIA |
| RHEUMATIC FEVER | DIABETES MELLITUS | POLIOMYELITIS |
| HIV | TUBERCULOSIS | HEP A, B, C  |
| LYME DISEASE | COVID-19 |  |
|  |  |  |

ANY OTHER ILLNESS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for mental illness\_\_\_\_\_\_\_\_\_\_\_Fracture\_\_\_\_\_\_\_\_\_Head injury\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE ANY HOSPITALIZATIONS, SURGERIES AND DATES---IF APPLICABLE

**FAMILY HISTORY:**

CANCER, DIABETES, HIGH BLOOD PRESSURE, HEART DISEASE, STROKE, ALLERGY, ASTHMA, ALCOHOL, ALZHEIMER’S DISEASE ETC

MOTHER MATERNAL PARENTS CHILDREN

FATHER PATERNAL PARENTS SIBLINGS

**BODY SYSTEM REVIEW**

**PLEASE CHECK ALL THAT APPLIES TO YOU**

**EARS, EYES, NOSE AND THROAT**

ARE YOU HARD OF HEARING YES NO

DO YOU HAVE CONSTANT NOISE IN YOUR EARS YES NO

HAVE YOU AT TIMES HAD BAD NOSE BLEEDS YES NO

HAVE YOU SUFFERED FROM A CONSTANT RUNNY NOSE YES NO

DO YOU EYES CONTINUALLY BLINK OR WATER YES NO

DO YOU OFTEN SEE SPOTS BEFORE YOUR EYES YES NO

IS YOU VISION POOR YES NO

DO YOU HAVE OFTEN PAIN IN YOUR EYES YES NO

DO YOU SUFFER FROM FREQUENT SORE THOATS YES NO

DO YOU SUFFER FROM FREQUENT EAR ACHES YES NO

**RESPIRATORY**

DO YOU FREQUENTLY SUFFER FROM HEAVY CHEST COLD YES NO

DO YOU SUFFER FROM ASTHMA YES NO

ARE YOU TROUBLED BY CONSTANT COUGHING YES NO

HAVE YOU EVER COUGED UP BLOOD YES NO

HAVE YOU EVER HAD A CHRONIC CHEST CONDITION YES NO

DO YOU OFTEN HAVE PAIN IN YOUR CHCEST WHEN TAKING DEEP BREATHS YES NO

**CARDIVASCULAR**

HAVE YOU EVER BEEN TOLD THAT YOU HAD HEART TROUBLE YES NO

DO YOU HAVE PAINS IN YOUR HEART OR CHEST YES NO

ARE YOU OFTEN BOTHERED BY THUMPING OF YOUR HEART YES NO

DOES EXERCISE OR EXCITEMENT CAUSE YOU TO HAVE PAINS IN YOUR HEART YES NO

HAS A DOCTOR EVER TOLD YOU THAT YOUR BLOOD PRESSUE IS TOO LOW YES NO

HAS A DOCTOR EVER TOLD YOU THAT YOUR BLOOD PRESSURE IS TOO HIGH YES NO

DO YOU HAVE DIFFCULTY BREATHING YES NO

DO YOU OFTEN STOP FOR REST WHEN WALKING UP A FLIGHT OF STAIRS YES NO

 HOW MANY FLIGHTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD TO SIT UP TO CATCH YOUR BREATH YES NO

ARE YOU ANKLES EVER BADLY SWOLLEN YES NO

HAS A DOCTOR EVER SAID THAT YOU HAVE VARICOSE VEINS YES NO

**GASTROINTESTINAL**

HAVE YOU HAD UNEXPLAINED WEIGHT LOSS YES NO

IS YOUR APPETITE ALWAYS POOR YES NO

DO YOU USUALLY BELCH A LOT YES NO

DO YOU USUALLY PASS A LOT OF GAS IN YOUR RECTUM YES NO

DO YOU SUFFER FROM INDIGESTION YES NO

DO YOU SUFFER FROM FREQUENT LOOSE BOWEL MOVEMENT (DIARHEA) YES NO

YOU CONSTANTLY CONSTIPATED YES NO

HOW MANY BOWEL MOVEMENTS DAILY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WEEKLY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU FREQUENTLY HAVE SEVERE STOMACH PAINS YES NO

DO YOU HAVE FREQUENT VOMITING YES NO

HAVE YOU EVER VOMITED BLOOD YES NO

HAVE YOU EVER PASSED BLOOD WITH YOUR BOWEL MOVEMENT YES NO

**GENITOURINARY**

DO YOU HAVE TROUBLE HOLDING YOUR URINE YES NO

HAVE YOU EVER DRIBBLED URINE WHEN SNEEZING YES NO

HAVE YOU EVER HAD BLOOD OR GRAVEL IN YOUR URINE YES NO

DO YOU OFTEN HAVE PAIN OR BURINING ON URINATION YES NO

HAVE YOU EVER HAD A KIDNEY DISEASE YES NO

DO YOU HAVE TROUBLE STARTING YOUR STREAM WHEN YOU URINATE YES NO

HOW IS YOUR ENERGY SEXUALLY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE SEXUAL RELATIONS PAINFUL OR DIFFICULT FOR YOU YES NO

HAVE YOU HAD A RECENT LOSS OF INTEREST IN SEXUAL RELATIONS YES NO

WHAT FORM OF BIRTH CONTROL DO YOU USE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN AND EXTREMITIES**

HAVE YOU HAD ARTHRITIS OR RHEUMATISM YES NO

ARE YOUR JOINTS OFTEN PAINFULLY SWOLLEN YES NO

DO YOU FREQUENTLY GET SEVERE LEG CRAMPS WHEN WALKING YES NO

DO YOU HAVE ANY SKIN RASHES YES NO

DESCRIBE ANY SCARS AND HOW ACQUIRED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NEUROMUSCULAR**

DO YOU SUFFER FROM FREQUENT SEVERE HEADACHES YES NO

ARE YOU USUALLY NERVOUS YES NO

DO YOU OFTEN HAVE SPELLS OF SEVERE DIZZINESS YES NO

DO YOU FREEQUENTLY FEEL FAINT YES NO

HAVE YOU HAD A LOSS OF STRENGTH OR FEELING IN ANY PART OF YOUR BODY YES NO

WAS ANY PART OF YOUR BODY EVER PARALYZED YES NODID YOU EVER HAVE A FIT OR CONVULSION YES NO

**HEMATOLOGY**

DO YOU BRUISE MORE EASILY THAN NORMAL YES NO

WHEN YOU CUT YOURSELF DO YOU BLEED EXCESSIVELY YES NO

DO YOU HAVE A HISTORY OF ANEMIA (LOW BLOOD COUNT) YES NO

**ENDOCRINE**

DO YOU HAVE A HISTORY OF HAVING HAD THYROID TROUBLE YES NO

WERE YOU GIVEN THYROID TABLETS TO TAKE YES NO

DO YOU HAVE ANY LUMPS OR BUMPS ANYWHERE IN YOUR BODY YES NO

**OBSTETRICS & GYNECOLOGY**

HOW OLD WERE YOU WHE YOU STARTED MENSTRUATING \_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOUR PERIODS USUALLY REGULAR YES NO

WHEN WAS YOUR LAST PERIOD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USUAL NUMBER OF DAYS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WEEKS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_IN A CYCLE

AMOUNT OF FLOW\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_COLOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CLOTTING\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD VAGINAL BLEEDING BETWEEN YOUR MENSTRUAL CYCLE YES NO

HOW MANY PREGNANCIES DID YOU HAVE YES NO

HOW MANY CHILDREN DID YOU HAVE YES NO

HAVE YOU HAD A MISCARRIAGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW MANY\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY VAGINAL BURNIGN OR ITCHING\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER HAD A BLOODY NIPPLE DISCHARGE YES NO

PLEASE DESCRIBE ANY DISCOMFORT BEFORE FLOW:

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF TREATMEN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE

**Statement of Acupuncture Procedures and Financial Policy**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Stewart M. Kaufman, LAC, to treat me by way of acupuncture procedures including but not limited to acupuncture, moxibustion and electro-stimulation. I understand acupuncture does not act as primarily as healthcare and the nature of consequences and benefits of these procedures have been explained to me sufficiently and completely in detail in any reiterated context below

1. Acupuncture is a system of therapeutic treatment which works on the body’s energy. Acupuncture procedures involve the insertion of exceptionally fine, sterile needles into the surface of the skin but can include the approaches of moxibustion, cupping, electro-stimulation, manual pressure, and other technique procedures to the practice of oriental medicine.
2. Potential risks may include pain or discomfort at the site of insertion of the needle, irritation, pain, and discomfort, bruising, weakness, fainting, nausea, and possible aggravation may occur. These risks are rare and can be minimized by the proper nutrition and rest prior to the treatment and communicating with the acupuncturist regarding any uncertainty on the part of the patient.
3. Potential benefits are enhanced by avoiding bathing and showering for several hours after treatment, resting appropriately, and following such general recommendations as the therapist may make. Acupuncture may allow for painless and drugless relief of my presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem as well as other health balancing effects.
4. I understand that any disease requires diagnosis by a licensed M.D. physician and any other change in pharmaceutical drug use should be medically monitored. Oriental medicine and acupuncture are not offered as primary care in the State of New York at this time, rather they are adjunctive therapies for complementary healthcare.
5. Our financial policy is that you SUBMIT FULL PAYMENT TO OUR RECEPTIONIST UPON LEAVING YOUR TREATMENT SESSION. You may pay by cash or check. We will provide you with a receipt suitable for submission to your health insurance carrier for tax purposes. You will give 24 hours’ notice for change of appointment or you will be charged the time that you are reserved. Late arrivals for body work sessions are liable for the full fee.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/guardian Date