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|  | ***Good Vibes Acupuncture & Herbs***  HEALTH HISTORY QUESTIONAIRE  **All questions contained in this questionnaire are strictly confidential and will become part of your medical record.** | | | |  |
| **Date**: | | | | | |
| **Name: □ M**  **(Last, First, MI) □ F** | | | **DOB:** | | |
| **Primary Care Physician: Phone number:** | | | | | |
| **Other healthcare practitioners:**  Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists, etc.: | | | | | |
| **Name: Type of practice: Phone number:** | | | | | |
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|  | | | | | |
| **Date of last physical exam:** | | **Date of last pap**  **Or prostate exam:** | | **Date of last**  **Fasting blood labs:** | |
| **Please list your current health concerns in order of their importance to you:** | | | | | |
| **Concern:** | | | **Date of last onset:** | | |
| **1.** | | |  | | |
| **2.** | | |  | | |
| **3.** | | |  | | |
| **4.** | | |  | | |
| **5.** | | |  | | |
| **Current or Previous medical diagnosis:** | | | | | |
| **Diagnosis:** | | **Diagnosis by:** | | **Date of diagnosis:** | |
| **1.** | |  | |  | |
| **2.** | |  | |  | |
| **3.** | |  | |  | |
| **4.** | |  | |  | |
| **5.** | |  | |  | |
| **Traumas, Car Accidents, Injuries:** | | | | | |
| **Surgeries and Hospitalizations:** | | | | | |
| **Year** | | **Reason** | | **Hospital** | |
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| **Have you ever had a blood transfusion? …………………………………………….**□Yes □ No | | | | | |

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| **Childhood Medical History** | |
| **Prenatal history:** Any complications during your mother’s pregnancy with you? □ **Yes** □ **No**  If so, describe: | |
| **Birth History:** □ Vaginal □ Cesarean Section □ Forceps □ Vacuum □ Trauma?  Any newborn problems? □ Jaundice □ Hospitalization □ Other, describe | |
| **Nourishment:** As a baby, were you fed □ Breast milk □ Formula □ Mixed  Do you know at what age you first were given solid foods? How would you describe your diet as a child? | |
| **Childhood Illness:** How often did you get sick as a child?  What kind of illnesses did you usually experience? i.e. ear infections, sore throat, cough, allergies, asthma…  How often did you take antibiotics?  Other medications taken regularly as a child? Did you ever have:  □ Measles □ Mumps □ Chicken Pox □ Rheumatic Fever  □ Polio □ Pertussis □ Other infectious diseases | |
| **List any other medical problems you had as a child:** | |
|  | |
| **Vaccinations**: □ I am fully vaccinated  □ I am selectively vaccinated  □ I am not vaccinated  Last tetanus booster:  Do you get the flu vaccine? □Yes □ No  Any adverse reactions to vaccine? □Yes □ No | **Check those vaccinations you’ve had:**  □ Chicken Pox □ Polio  □ DPT □ PPD  □ Hepatitis □ MMR  □ HIB □ Pneumonia |
| Home Environment: | |
| How many children in your family? Your birth order (3rd of 4 kids….) | |
| What adults lived with you? | |
| Did you have any traumas or losses as a child? | |
| Was your home safe? | |
| Did you grow up in the city, suburbs, or in a rural area? | |
| Any difficulties in school? | |
| Did anyone in your home smoke or use drugs regularly? | |

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| **FAMILY HEALTH HISTORY** | | | | | | |
| Are you adopted?............................................................................................ □ Yes □ No  Family history, note relationship below. | | | | | | |
| □ High blood pressure □ Diabetes □ Allergies □ Epilepsy | | | | | | |
| □ Tuberculosis □ Stroke □ Cancer □ Substance Abuse | | | | | | |
| □ Heart disease □ Kidney disease □ Obesity □ Osteoporosis | | | | | | |
| □ Thyroid disorder □ Arthritis □ Autoimmune disease □ Other | | | | | | |
| Relationship | Age | Age at  Death | Significant health problems or  cause of death: | Children’s Age | Age at  death: | Significant  health problems or  cause of death: |
| Father |  |  |  | □ M  □ F |  |  |
| Mother |  |  |  | □ M  □ F |  |  |
| Brothers  And sisters □ M  □ F |  |  |  | □ M  □ F |  |  |
| □ M  □ F |  |  |  | Grandparents (mother’s Side) | | |
| □ M  □ F |  |  |  | Male |  |  |
| □ M  □ F |  |  |  | Female |  |  |
| □ M  □ F |  |  |  | Grandparents (Father’s side) | | |
| □ M  □ F |  |  |  | Male |  |  |
| □ M  □ F |  |  |  | Female |  |  |
| Please leave this space blank for physician use. | | | | | | |

**MEDICATIONS**

Prescription Medications Strength Frequency Taken

Over The Counter Drugs Strength Frequency Taken

Vitamins and Other Supplements Strength Frequency Taken

**ALLERGIES**

Name of Drug Reaction

Allergies to Foods:

Environmental Allergies:

Notes:

**DIET Diet:** Do you describe your diet as:

□ Vegetarian □ Vegan □ Macrobiotic □ Other

Do you restrict calories?....................................... □ Yes □ No

How often do you eat?

# of times you eat restaurant food each week? Where do you grocery shop?

Do you buy organic foods? What %? Foods you restrict:

What foods do you crave?

Any foods you strongly dislike?

Have you ever had an eating disorder?

Describe what you have eaten in the last 24 hours, be specific…

Time: Food eaten-describe ingredients Amount

Water (how much): Source: □ Tap □ Brita □ Bottled □ Filtered □ Well

Other beverages:

How often do you eat the following:

Fish Fresh Vegetables Red meat Dark leafy greens Eggs Citrus fruits

Dairy Sweets Wheat Fruit juice Salads

List any food allergies or intolerances:

Food eaten Reaction Timing

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| **OTHER LIFESTYLE FACTORS** |
| **Activity**: □ Sedentary (no exercise)  □ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)  □ Occasional Vigorous Exercise (i.e. work or recreation **less** than 4x/week for 30 min.)  □ Regular Vigorous Exercise (i.e., work or recreation 4x/wk. for 30 min.) After moderate or vigorous exercise, do you feel □ great □ drained |
| **Weight**: Current weight: □ Don’t know  Ideal body weight:  What is the most and least you have weighed as an adult? (excluding pregnancies)  Do you have, or have you ever had, an eating disorder?.....................□ Yes □ No  □ Binging □ Purging □ Avoidance of food  Do you diet or lose weight?............................................................... □ Yes □ No  Do you take medications, herbs or supplements to lose weight? □ Yes □ No  For physician to fill out:  **BMI** |
| **HOME** Is your home a sanctuary for you?................................................................□ Yes □ No  Do you live in an □ apartment □ house □ other Year building was built?  Who lives with you?  Name Relationship  Do you live with animals? If so, describe.  Does your home have lead paint……………………………………….......□ Yes □ No Is your home moldy?.....................................................................................□ Yes □ No Do you have □ telephone □ electricity/heat □ enough food  Is your home safe? …………………………………………………………□ Yes □ No  Is there a gun in your home? ……………………………………………….□ Yes □ No |
| **OCCUPATION** Do you work primarily inside the home?.................................... □ Yes □ No  Do you work outside the home?......................................................□ Yes □ No  If so, what type of work?  How many hours a week do you work? How many days a week?  Do you spend most of your day at a desk or computer?..................□ Yes □ No Do you take vacations?....................................................................□ Yes □ No Are you happy in your work? □ Yes □ No  Comments: |
| **HOBBIES** What do you do for fun? What do you like to do in your spare time? |

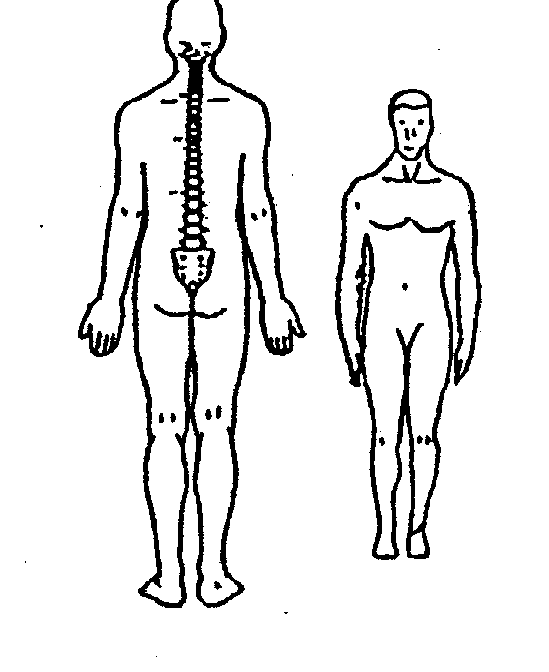
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| **HABITS** | | | |
| **Alcohol:** Do you drink alcohol?....................................................... □ Yes □ No  If yes, what kind? How many drinks per week?  Are you concerned about the amount you drink? ………...□ Yes □ No Have you considered stopping?........................................... □ Yes □ No Have you ever experienced blackouts?................................ □ Yes □ No Are you prone to “binge” drinking? ………………………□ Yes □ No Do you drive after drinking?................................................. □ Yes □ No | | | |
| **Tobacco:** Do you use tobacco?............................................................. □ Yes □ No  □ Cigarettes-pks/day □ Chew-# day □ Pipe- #/day  □ Cigars- #/day □ # of years □ or Year Quit | | | |
| **Drugs:** Do you currently use recreational or street drugs?............... □ Yes □ No  Have you ever given yourself street drugs with a needle?..... □ Yes □ No | | | |
| **Caffeine**: Coffee……………………………..□ Yes □ No Amount: Soda……………………………… □ Yes □ No Amount: Caffeinated tea……………………□ Yes □ No Amount: Other……………………………..□ Yes □ No Amount | | | |
| **TOXIC EXPOSURES** | □ Pottery  □ Glass blowing  □ Painting  □ Model building  □ Cleaning chemicals  □ Anesthesia | □ Nuclear power plant  □ Frequent Air Travel  □ Electric power lines  □ Mercury fillings  □ Other mercury exposure  □ Lead paint | □ Asbestos  □ Second hand smoke  □ Other solvents  □ Other heavy metals  □ Pesticides  □ |
| **Notes for physician:** | | | |

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| **SEXUAL AND REPRODUCTIVE HEALTH FOR PREMENOPAUSAL WOMEN** | |
| **All questions contained in this questionnaire are optional and will be kept strictly confidential**. | |
| Menstrual History Menstrual Symptoms  *Check if you experience any of the following*:  What age did you first menstruate? □ Cramps  What was the first day of your most recent period? □ Swelling  How long is your cycle, month to month? □ Breast tenderness  Is your cycle length regular? □ Mood swings  How many days do you bleed? □ Anxiety, Irritability Is your flow □ light □ moderate □ heavy □ Cravings Describe: PMS? □ Yes □ No Describe: □ Fatigue  Do you skip periods? □ Yes □ No □ Confusion  Any mid cycle spotting? □ Yes □ No □ Acne  □ None | |
| **Gynecologic Conditions**  *Check if you have had any of the following?*  □ Genital Herpes □ PCOS  □ Genital warts □ Endometriosis  □ Gonorrhea □ Uterine fibroid  □ Chlamydia □ Ovarian Cyst  □ Syphilis □ Breast lump  □ Hepatitis □ Fibrocystic breasts  □ HIV □ Nipple discharge  □ PID □ Pain with intercourse  □ Yeast Infection □ DES exposure  □ Bacterial Vaginosis □ Itching, odor, discharge  □ Trichimonas □ None | **Sexual History**  Are you sexually active? □ Currently □ past □ never  Age you were first consensually sexually active?  Partners? □ Male □ Female □ Both  Are you in a monogamous relationship? □ Yes □ No Total number of different sexual partners How many of these have been within the last year? Do you have difficulty having an orgasim? □ Yes □ No Do you feel knowledgeable about safe sex? □ Yes □ No Do you practice safe sex? □ Yes □ No  Have you ever been raped? □ Yes □ No Age?  □ Once □ Often? Number of times  Have you ever been sexually abused/molested? □ Yes□ No  Any other concerns? □ Yes □ No  Have you ever had an STD screening? □ Yes □ No  Have you ever had an abnormal pap? □ Yes □ No  Date of last annual gyn exam with pap? |
| **Pregnancy History:**  **Date: Outcome Breastfed? How long?** | |
| **Are you currently pregnant? ………………………………………………..□ Yes □ No**  **Do you plan to become pregnant in the future?................................................... □ Yes □ No**  **If so, when?**  **Have you ever had difficulty getting or staying pregnant?....................................... □ Yes □ No** | |
| **Contraceptive History: What birth control methods have you used?** *(Fertility awareness, condoms, sponge, cap, diaphragm, IUD, oral contraceptives, norplant, Depo-provera…)*  Type: How long? Any problems? Current Use? | |

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| **REVIEW OF SYSTEMS** | | | |
| **Check if you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.** | | | |
| **CONSTITUTIONAL** | | | |
| □ Weight  □ Energy level  □ Sleep | □ Appetite  □ Strength  □ Night sweats | | □ Sense of well-being  □ Libido |
| **EYES, EARS, NOSE, MOUTH, THROAT** | | | |
| □ Vision loss  □ Double vision  □ Excessive tearing  □ Dry eyes  □ Blind spots  □ Eye pain  □ Eye discharge | □ Hearing loss  □ Ringing in the ears  □ Vertigo/dizziness  □ Nose bleeds  □ Chronic stuffy nose  □ Post nasal drip  □ Recurrent sinus infections | | □ Headaches  □ Missing teeth  □ Gingivitis  □ Bad breath  □ Neck stiffness or swelling |
| **HEART AND BLOOD VESSELS** | | | |
| □ Chest wall pain  □ Palpitations  □ Short breath w/mild exercise  □ Short of breath lying flat | □ Heart murmur  □ Varicose veins  □ Clotting disorder  □ Vessel inflammation | | □ Fainting  □ Swelling  □ Leg pain when walking  □ Anemia |
| **LUNGS** | | | |
| □ Painful breathing  □ Shortness of breath | □ Wheezing  □ Cough  □ Chronic bronchitis | | □ Coughing sputum  □ Coughing blood |
| **MUSCULOSKELETAL** | | | |
| □ Back pain  □ Scoliosis  □ Bone loss/fractures | □ Muscle weakness  □ Muscle cramps  □ Muscle pain | | □ Joint pain  □ Morning stiffness  □ Hot/red muscles or joints  □ Limited range of motion |
| **NEUROLOGIC AND PSYCHOLOGICAL** | | | |
| □ Seizures, convulsions  □ Paralysis  □ Numbness/tingling  □ Tremor | □ Lack of coordination  □ Speech difficulties  □ Anxiety  □ Depression | | □ Bipolar disorder  □ Suicidal history |
| **IMMUNE SYSTEM** | | | |
| How many times a year do you get sick?  Do you recover easily?  □ Lymph node swelling | |  | |
| **ENDOCRINE** | | | |
| □ Breast enlargement-men  □ Thyroid problems  □ Heat or cold intolerance  □ Excessive urination  □ Excessive thirst | | □ Spacey feeling after food  □ Waking at night  □ Fainting  □ Swelling  □ Leg pain when walking | |

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| **ELIMINATION** | | |
| **GUT** | How often do you have a bowel movement? Is your stool:  □ Formed □ Loose □ Hard □ Dry □ Greasy  □ Brown □ Tan □ Black □ Green □ Yellow  In your stool, do you ever notice: □ Undigested food □ Bright red blood □  Mucous  Do you strain to pass stool?............................................ □ Yes □ No Do you have hemorroids?............................................... □ Yes □ No Do you experience gas, bloating, or belching daily?....... □ Yes □ No Do you ever unintentionally pass stool?.......................... □ Yes □ No | |
|  | □ Abdominal pain  □ Heartburn/indigestion  □ Nausea/ vomiting | □ Recent change in bowel movements  □ Constipation  □ Diarrhea |
| **KIDNEYS** | How often do you urinate?  Do you have any of the following?  □ Pain with urination □ Must get up at night to urinate  □ Urinate too frequently/too much □ Leaking urine  □ Urgency to urinate □ when laughing or coughing  □ Urinary flow obstruction □ at other times  □ Dribbling at end of urination □ Kidney Stones  □ Recurrent urinary tract infections | |
| **SKIN** | Do you sweat easily? What makes you sweat?  Do you regularly apply lotion or oils to your skin? If so, what type? Do you scrub or dry brush your skin regularly?  Note if you have or have had any of the following:  □ Acne □ Moles  □ Eczema □ Hives  □ Rash □ Pigment changes  □ Chronic itching □ Skin cancer  □ Dry skin □ Hair loss or unusual growth  □ Contact dermatitis □ Jaundice—yellowing of the skin | |
| **LUNGS** | Note if you have had any of the following:  □ Asthma □ Can’t sleep flat □ Chronic cough  □ Painful breathing □ Difficulty breathing □ Recurrent lung infections | |
| **LIVER** | Note if you have had any of the following:  □ Yellowing of the skin  □ Chronic itching  □ Nausea/vomiting  □ Abdominal pain  □ PMS  □ Menstrual irregularities | Are you unable to tolerate:  □ Cigarette smoke  □ Perfume  □ Alcohol  □ Caffeine |

Please indicate on the drawings the location and type of symptoms that you are experiencing.



A = Aching

B = Burning

SB = Stabbing PN = Pins /Needle N = Numbness

SPT = Spasm/ Tight

Write out any other problems

**Good Vibes Acupuncture & Herbs**

**Financial Policy**

Thank you for choosing Good Vibes Acupuncture & Herbs. We are committed to providing the best medical care possible. The following statement explains our financial policy which we ask you to read, sign and return to us prior to your treatment. Complementary Medicine may be covered by some PPO plans. Check with your insurance company to determine if this is a covered benefit.

***Returned Checks***

For checks returned to us as unpaid by your bank, you will be charged a ***$25 fee***.

***Missed Appointments***

Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge ***$25 for missed appointments without appropriate notice***. Please help us to serve you better by keeping scheduled appointments.

***Payment Plans***

If you are unable to pay your balance in full at the time of your visit, payment arrangements may

be made. Please discuss your situation with Cathy Margolin L.Ac. so she can create a plan for you

***Past Due Accounts***

If a payment plan is not in place and your account becomes overdue, your account will be

referred to a collection agency. Legal fees that we incur to secure past due balances will be added to your account.

**Consent to Treat**

I consent to the use and/or disclosure of my protected health information to Cathy Margolin L.Ac. for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that my physician is a licensed Acupuncturists and Diplomate of Eastern Oriental Medicine Physician. I understand and agree that diagnosis or treatment of me and my physician may be conditioned upon my consent as evidence by my signature on this document. I understand that I am financially responsible for the charges that I incur during my treatment under the care of Cathy Margolin. I have read and agree to the financial policy. Please request a copy of our Privacy Practices if you have any questions or concerns.

**I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE, I AM RESPONSIBLE FOR THE BALANCE ON THIS ACCOUNT FOR ANY SERVICES, SUPPLEMENTS, MEDICINES, AND LABORATORY WORK.**

Print Name of Patient

Signature of Patient

Date