

PATIENT DATA:

Date: _____

Name: _____

Address: _____

City/State/Zip: _____

Phone: (h) _____ (w) _____ (cell) _____

Date of Birth: _____ Age: _____ Email: _____

Circle One: single partnered married separated divorced widowed Gender: _____

Occupation: _____ Name of Spouse/Partner or Parent (if child) _____

Emergency contact: (name) _____ (phone) _____

How did you learn about our office? _____

Current Physician _____ Diagnosis by MD _____

Which of the following have you experienced before? **Circle all that apply:** Acupuncture Herbal Medicine

Chiropractic Massage Hypnosis Emotional Freedom Techniques Dietary Consultation

PRIMARY COMPLAINTS:

- 1.
- 2.
- 3.

MEDICAL HISTORY:

MEDICATIONS: Please list all prescribed (allopathic) drugs, non-prescribed medications, vitamins, herbs etc., you are taking, stating what they are used for.

- 1.
- 2.
- 3.
- 4.

Please check: Do you use or do any of the following on a regular basis?

Alcohol	Tobacco	Drugs	Coffee or Tea	Exercise	Soft drinks	Sugar	Soy Products	Wheat/ Gluten	Vegetarian diet
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Please list any hospitalizations, accidents, and past illnesses. Include dates and ages.

- 1.
- 2.
- 3.
- 4.

Please list any serious diseases in your family history such as Cancer, Diabetes, Hypertension, Heart disease etc.

Mother: _____ Father: _____

Grandparents: _____ Siblings: _____

Please check current complaints

Musculoskeletal

Neck Pain	Hip Pain	Leg Cramps
Back Pain	Knee Pain	Muscle Atrophy
Hand/Wrist Pain	Foot/Ankle Pains	Muscle Pains
Elbow Pain	Hernia Pain	Muscle Spasms
Arm Pain	Deformities of Bones	Muscle Weakness
Shoulder Pain	Brittle Bones	Areas of Numbness & Tingling
Rib Pain	Joint Swelling	Other:

Neurophysiological/ Emotional

Seizures	Convulsions	Poor Memory/Concentration
Regions of Numbness	Dizziness	Anxiety
Head Injury	Lack of Coordination / Balance	Sadness
Bad Temper	Low Stress Tolerance	Weepy
Worry, Over-thinking	Fearful	Depression
Mood Swings	Suicidal	Paralysis
Confusion	Tremors / Tics	Mental Illness

General

Night Sweats	Sleep Too Much	Rashes
Fevers / Chills	Insomnia	Fungal Infections
Hot or Cold Intolerance	Nightmares	Psoriasis
Spontaneous Sweating	Bleed or Bruise Easily	Eczema
Weakness	Swollen Glands	Itchy or Dry Skin
Fatigue	Cravings	Acne
Sudden Energy Drop: time?	Weight Gain/Loss	Ulcerations
Auto-Immune disease	Dental amalgam fillings	Infections e.g. HIV+, Lyme, EBV
Immune issues like high ANA titer	Hair loss	Premature birth
Forceps delivery	Held in an incubator	Life threatening event

Cardiovascular

High Blood Pressure	Irregular Heartbeat	Swelling of Feet/Hands
Low Blood Pressure	Rapid Heartbeat / Palpitations	Blood Clots
Chest Pain	Fainting	Varicose Veins

Respiratory

Asthma	Bronchitis	Sinus Congestion
Allergies	Pneumonia	Production of Phlegm: Color?
Cough	Difficulty Breathing	Nose Bleeds
Coughing Blood	Catch Colds Frequently/Easily	Other:

Gastrointestinal

Increased Appetite	Bad Breath	Mouth Sores
Decreased Appetite	Belching	Excessive Thirst
Nausea	Hiccups	Problems Swallowing
Vomiting	Gas	Heartburn / Reflux / Indigestion

Oriental Health Solutions, LLC, 907 Broad St., Durham, NC 27705 - New Patient Questionnaire

Food Sits in Stomach	Hiatal Hernia	Parasites
Peculiar Tastes / Smells	Constipation	Itchy Anus
Gallstones	Diarrhea	Food Allergies
Hepatitis	Loose Stools	Desire for Hot / Cold Foods
Hemorrhoids	Anal Fissures	Dark / Light / Bloody stools
Current Weight _____ lbs	Rectal Pain	Other GI issue:

Genito-Urinary

Painful / Difficult Urination	Decrease in Flow	Urinary Tract Infection
Urgency to Urinate	Dark / Odorous Urine	Interstitial Cystitis
Frequent Urination	Unable to Hold Urine	Kidney Stones
Blood in Urine	Bedwetting	Genital Sores
Cloudy Urine	Night time Urination	Edema: where? _____

Head, Eyes, Ears & Throat

Headaches	Light Sensitivity	Earaches
Migraines	Red / Itchy Eyes	Ringing in Ears
Fainting	Poor Night Vision	Dizziness
Pressure in Eyes / Ears	Spots in Front of Eyes / Floaters	Sores on Lips / Tongue
Eye Pain	Poor Hearing	Grinding Teeth

Women

Cycle Length: _____ days	Vaginal Dryness	Increased / Decreased Libido
Days of bleeding: _____ days	Endometriosis	Hot Flashes
Heavy or Light Periods	Method of Birth Control?	Night Sweats
Menstrual Blood Color: _____	Number of Pregnancies _____	Sexually Transmitted Disease
Menstrual Pain	Number of Children _____	HPV positive? Yes No
Clots	Number of Abortions _____	Vaginal Discharge/ Sores
PMS	Difficult Birth / Caesareans	Breast Problems
Polycystic Ovarian Disease (PCOS)	Are you pregnant? Yes No	Age Menses began _____
Irregular or No Periods	Date of last PAP? _____	Age at Menopause _____
Female Fertility issues	Infertility	Number of Miscarriages _____
Anovulation	Luteal Phase Problems	Pelvic Inflammatory Disease
Used birth control pills or Depo-Provera	Tested positive for Chlamydia? Yes No	# of IUI or IVF cycles? _____
FSH level _____ AMH level _____	Fibroids Adhesions Cysts	Low Progesterone

Males

Prostate Problems	Painful / Swollen Testicles	Discharge
Erectile Dysfunction	Increased / Decreased Libido	Sexually Transmitted Disease
Male Fertility issues	Infertility	Varicocele
Undescended testicles	Sperm Analysis normal? Yes No	Immune issues like Antisperm Antibodies

Anything else you would like us know: _____

Health Questionnaire - Please circle appropriate number: 0=never/least, 1=occasionally, 2=frequent, 3=all the time

SECTION - A	0	1	2	3	How often do you feel you lack artistic appreciation?	0	1	2	3
Is your memory noticeably declining?	0	1	2	3	How often do you feel depressed in overcast weather?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3	How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3	How much are you losing enjoyment for your favorite foods?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3	How much are you losing enjoyment of friendships and relationships?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3	How often do you have difficulty falling into deep restful sleep?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3	How often do you have feelings of dependency on others?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3	How often do you feel more susceptible to pain?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3	How often do you have feelings of unprovoked anger?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3	How much are you losing interest in life?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3	SECTION 2 - D	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3	How often do you have feelings of hopelessness?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3	How often do you have self-destructive thoughts?	0	1	2	3
SECTION - B	0	1	2	3	How often do you have an inability to handle stress?	0	1	2	3
How high is your stress level?	0	1	2	3	How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3	How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3	How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3	How often do you have unexplained lack of concern for family and friends?	0	1	2	3
Do you find it difficult to get regular exercise?	0	1	2	3	How easily are you distracted from your tasks?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3	How often do you have an inability to finish tasks?	0	1	2	3
Do you feel you are not accomplishing your life's purpose?	0	1	2	3	How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3	How often do you feel your libido has been decreased?	0	1	2	3
SECTION C1	0	1	2	3	How often do you lose your temper for minor reasons?	0	1	2	3
How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3	How often do you have feelings of worthlessness?	0	1	2	3
How often do you feel energized after eating?	0	1	2	3	SECTION 3 - G	0	1	2	3
How often do you have difficulty eating large meals in the morning?	0	1	2	3	How often do you feel anxious or panic for no reason?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3	How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3	How often do you feel knots in your stomach?	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3	How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3	How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3	How often does your mind feel restless?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3	How difficult is it to turn you mind off when you want to relax?	0	1	2	3
SECTION - C2	0	1	2	3	How often do you have disorganized attention?	0	1	2	3
Do you get fatigued after meals?	0	1	2	3	How often do you worry about things you were not worried about before?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3	How often do you have feelings of inner tension and inner excitability?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3	SECTION 4 - ACH	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3	Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3	Do you feel your verbal memory is decreased?	0	1	2	3
Do you suffer from frequent urination?	0	1	2	3	Do you have memory lapses?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3	Has your creativity been decreased?	0	1	2	3
Do you experience weight gain when under stress?	0	1	2	3	Has your comprehension been diminished?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3	Do you have difficulty calculating numbers?	0	1	2	3
SECTION 1 - S	0	1	2	3	Do you have difficulty recognizing objects & faces?	0	1	2	3
Are you losing your pleasure in hobbies and interests?	0	1	2	3	Do you feel like your opinion about yourself has changed?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3	Are you experiencing excessive urination?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3	Are you experiencing slower mental response?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3					
How often do you feel sad or down for no reason?	0	1	2	3					
How often do you feel like you are not enjoying life?	0	1	2	3					