

Integrative Acupuncture Therapy LLC



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Licensed Acupuncturist/Chinese Herbalist

Date: _____

Please fill out this CONFIDENTIAL questionnaire completely and legibly. It will help us determine the best treatment for you.

Personal Information

Name: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ u Work #: _____ Mobile: _____

Occupation: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Who can I thank for referring you? _____

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

Sex: M F Height: _____ Weight: _____ Birthdate: ____/____/____ Age: _____

Marital Status: Married Single Divorced Widowed Spouse name: _____

Previous Acupuncture? Yes No When? _____ With Who? _____

Concurrent Health Therapies or Regimens: _____

Treatments that made condition better: _____ Made condition worse: _____

Please indicate any significant illness you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?
Alcoholism/Addiction	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexually Transmitted Diseases: Gonorrhea Syphilis HIV HPV Chlamydia Herpes Date? _____

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount
Coffee/black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreation drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soda/pop	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laxatives	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pain relievers	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please check the box if any of the following statements is true:

I have known allergies, such as latex. Please list: _____

I have a pacemaker or other implant device. Please list: _____

I have artificial joints, screws, plates, or pins in my body. Please list: _____

I am taking Coumadin/warfarin.

I am taking lithium (Eskalith, Lithobid, Lithonate, and Lithotabs.)

Please list any major surgeries, accidents, trauma, or hospitalizations:

Surgeries, Accidents, Hospitalizations	Date	Reason

How do you feel about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may experience.

	Great	Good	Fair	Poor	Bad	Comments
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Exercise & Energy

How would you rate your energy? Great Good Fair Poor Tired all of the time

What time of day is your energy highest? _____ Lowest? _____

What kind of exercise do you do? _____ How often? _____

SYMPTOM SURVEY

Please check any symptoms that you currently have or have had in the past year:

General

- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Hot flashes
- Insomnia
- Numbness
- Sweat spontaneously
- Night sweats
- Lack of sweating
- Sudden weight loss
- Sudden weight gain
- Intolerant of heat
- Intolerant of cold
- Aversion to wind

Head & Neck

- Blurred vision
- Heaviness in the head
- Headache
- Phlegm in throat
- Cataract
- Double vision
- Earache/ear infection
- Ear discharge
- Eye pain/strain
- Corrected vision
- Nasal obstruction
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nosebleeds
- Recurrent sore throat
- Red/inflamed eye
- Ringing in ears
- Sinus problems
- Sores on lips
- Taste change
- Teeth problems
- Seeing halos or floaters

Respiratory

- Asthma
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production
- Difficulty inhaling
- Difficulty exhaling

Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heartbeat
- Poor circulation
- Swelling, edema
- Varicose veins
- High cholesterol
- Pressure in the chest
- Distention in chest

Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Black stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting
- Vomiting blood
- Difficulty digesting oily or fatty foods
- Pin under the ribs

- Excessive appetite
- Use of antibiotics
- Light colored stool

Musculoskeletal

Pain, weakness, numbness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold hands and feet
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Sciatic pain

Genitourinary

- Profuse urine
- Dark or cloudy urine
- Blood in urine
- Organ prolapsed
- Burning urination
- Scanty urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

Skin & Hair

- Thickening of skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles under eyes
- Bags under eyes
- Lumps in groin
- Lumps under arm
- Dry skin
- Acne

- Brittle or soft nails
- Premature gray hair
- Dry, brittle hair
- Hair falling out
- Hives, rashes, eczema

Neurological

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures
- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

Emotional

- Nervousness
- Irritability
- Mentally restless
- Easily angered
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Cloudy mind
- Anxiety
- Fearful
- Difficulty expressing emotion

Diet/Lifestyle

- Vegetarian
- Healthy diet
- Eat fried foods
- Eat fast food
- Eat red meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Eat lots of sweets
- Cravings
- Type: _____
- Take steroids

Exercise regularly Underweight Overweight
 Exercise excessively **Weight** Normal for height Very overweight

FOR WOMEN

Age of first period (menarche): _____ Are you pregnant? Yes No # of pregnancies: _____
Age of last period (menopause): _____ # of live births: _____ # of abortions: _____ # of miscarriages: _____
Number of days between periods: _____ Date of last: Gynecological exam _____ Pap smear _____
Number of days of flow: _____ Mammogram: _____ Bone Density Scan: _____
Color of flow: _____ Results: _____

Clots? Yes No Color _____

Average # of pads/tampons you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ +days _____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian cysts PID Other

Location of pain: Lower abdomen Lower back Thighs Other _____

Nature of pain (please indicate before, during or after menses)

Other symptoms related to menses

Cramping _____	Stabbing _____	<input type="checkbox"/> Discharge	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Headache
Burning _____	Aching _____	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
Dull _____	Bloating _____	<input type="checkbox"/> Swollen breasts	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Ravenous appetite
Consistent _____	Intermittent _____	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Night sweats
Bearing down sensations _____		<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Insomnia

Are you using oral contraceptives? Yes No

FOR MEN

Date of last prostate check-up: _____ PSA results: _____ Manual prostate exam results: _____

Lab results: _____

Frequency of urination: Daytime _____ Nighttime _____ Color of urine: Clear Cloudy Odor

Symptoms related to prostate:

<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Delayed stream	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Retention of urine
<input type="checkbox"/> Rectal dysfunction	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Impotence
<input type="checkbox"/> Back pain	<input type="checkbox"/> Groin pain	<input type="checkbox"/> Testicular pain	<input type="checkbox"/> Other _____	

Please sign and date below.

I understand that I should be evaluated by a physician for the condition for which I am requesting consultation. The diagnosis and treatment plan I will be given by Integrative Acupuncture Therapy is based on traditional Chinese medical principles and natural treatment only, and does not constitute a Western medical diagnosis. I understand that I am not to rely on traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to see advice from a Western medical doctor. Further, if I am concurrently undergoing Western medical treatments, it is my responsibility to advise my physician of any herbal and dietary supplements I am concurrently taking.

Signature: _____

Date: _____

MEDICATIONS, HERBAL, and OTHER SUPPLEMENTS

Patient Name: _____

Date: ____ / ____ / ____

Are you presently taking any of the following medications?

- | | | | |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------|------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Analgesics
(Aspirin, Ibuprofen, Naproxen, Sodium) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cardiovascular Agents
(Digoxin, Lanoxin, Captopril) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Laxatives | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Antacids
(Bicarbonate of Soda, calcium carbonate) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Sedative, Anti-anxiety, Antipsychotic drugs
(Lithium, Thioridazine, Chlorpromazine, Prozac) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Anti-Inflammatories
(Prednisone, other corticosteroids, NSAIDs) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Agents
(Theophylline) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diuretics
(Lasix) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Antibiotics | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Elixirs containing sorbitol
(Theophylline, Acetaminophen) | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Insulin or Diabetic Pill | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleeping pills | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Medication | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood-thinning pills | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure medication | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Reducing pills | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Birth Control pills | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Hormones | Dosage | Frequency |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Pressure pills | Dosage | Frequency |

List any other including over-the-counter medications you currently take/use:

Please list any herbal or other natural supplements, vitamins and minerals you are taking:

Please bring in your supplements and medications to your next visit.

Do you feel the herbal, natural supplements are helping you?

Are you allergic to any medications, natural supplements, or over-the-counter medications? Please name and describe reaction. _____