

Acupuncture Health History Questionnaire

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (C) _____ (W) _____

E-Mail: _____ Emergency Contact: _____

Gender: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Referred By: _____ Family Physician: _____

Occupation: _____ Hobbies: _____

Have you been treated by acupuncture before? _____

In order of priority name 5 problems you like for us to help you with. _____

To what extent do these problems interfere with daily activities, (work, sleep, sex)? _____

What types of treatment have you tried? _____

Have you been given a diagnosis for this problem and if so what? _____

Medical history: (please include dates). _____

Current Illnesses: (please circle) Cancer Diabetes Hepatitis Seizures High Blood Pressure Rheumatic Fever

Thyroid Disease Venereal Disease Others: _____

Any Trauma? (Auto accidents, falls, etc.) _____

Your Birth History: (prolonged labor, forceps delivery, etc.) _____

Allergies:(medication, chemicals, food) _____

Family Health History: Cancer Asthma Stroke High Blood Pressure Seizures Allergies Diabetes Heart Disease

Medication taken within the last two months (vitamins, drugs, herbs, etc.) _____

Occupation & Occupational Stress (chemical, physical, psychological)? _____

Do you have a regular exercise program? Please describe _____

Have you ever been on a restricted diet? _____ What type? _____

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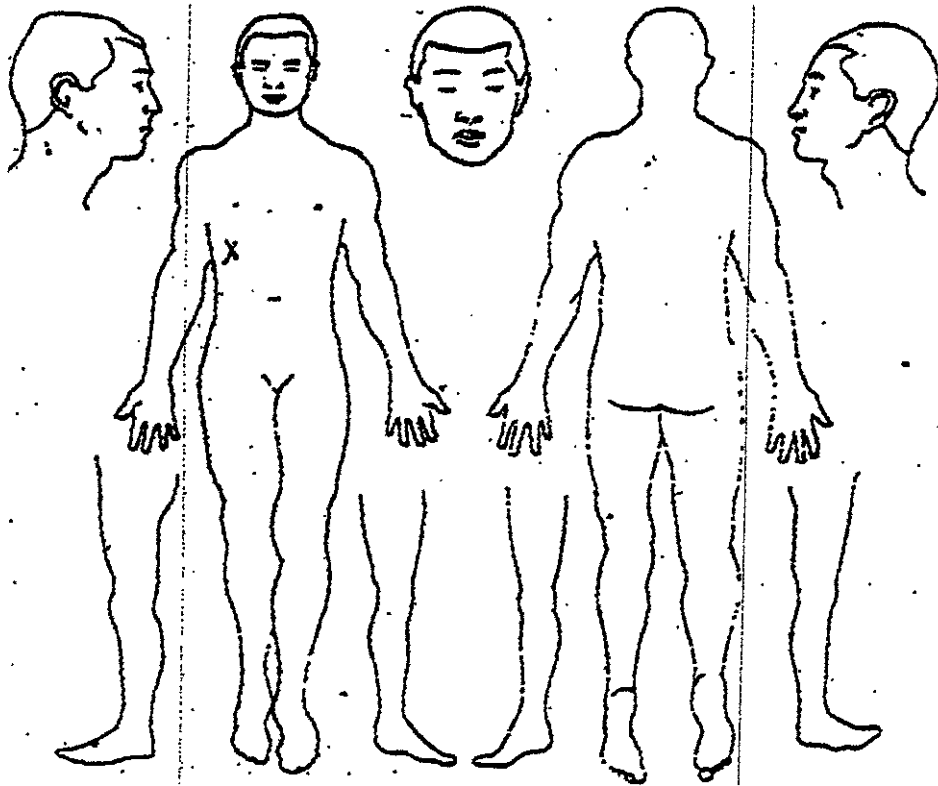
Please describe your average daily diet: _____

Do you smoke, how much? _____ Do you drink coffee/tea or cola and how much? _____

Do you drink alcohol and how much? _____

Please describe any use of drugs for non-medical purposes: _____

Please indicate painful or distressed areas and rate the pain level 1 to 10. _____



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Females Only: Pregnancy and Gynecology

Number of pregnancies: ____ Number of births: ____ Premature births: ____ Miscarriages: ____

Abortions: ____ Age at first menses: ____ Time between menses: ____ Duration: ____

Irregular periods? ____ Painful periods? ____ Clots? ____ Date of last PAP? ____

First date of menses: ____ Vaginal discharge? ____ Vaginal sores? ____ Breast Lumps? ____

Unusual (heavy/light?) _____

Changes in body /psyche prior to menstruation: _____

Do you practice birth control? ____ What type and for how long? _____

Genital-Urinary: Please circle if applicable and rate the pain/occurrence from 1 to 10

Pain on urination ____ Frequent urination ____ Blood in urine ____ Urgency to urinate ____ Kidney Stones ____

Unable to hold urine ____ Decrease in flow ____ Impotency ____ Sores on genitals

Do you wake from sleep to urinate? ____ How often? ____ Any particular color to your urine? _____

Any other problems with your genital or urinary system? _____

Gastrointestinal: Please circle if applicable and rate the pain/occurrence from 1 to 10

Nausea ____ Vomiting ____ Diarrhea ____ Constipation ____ Gas ____ Belching ____

Black stools ____ Blood in stools ____ Indigestion ____ Bad breath ____ Rectal Pain ____

Hemorrhoids ____ Abdominal pain or cramps ____

Any other problems with your stomach or intestines? _____

Musculoskeletal: Please circle if applicable and rate the pain/occurrence from 1 to 10

Neck pain ____ Back pain ____ Muscle pain ____ Hand / Wrist Pain ____ Shoulder Pain ____

Muscle weakness ____ Foot / Ankle pain ____ Hip pain ____

Any other joint or bone problems? _____

Psychological: Please circle if applicable and rate the pain/occurrence from 1 to 10

Seizures ____ Dizziness ____ Loss of balance ____ Areas of numbness ____ Poor Memory ____

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Psychological, continued: Please circle if applicable and rate the pain/occurrence from 1 to 10

Lack of coordination _____ Concussion _____ Depression _____ Anxiety _____ Bad Temper _____

Easily susceptible to stress _____ Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Have you had neurological or psychological problems? _____

General: Please circle if applicable and rate the pain/occurrence from 1 to 10

Poor appetite _____ Poor sleeping _____ Fatigue _____ Fevers _____ Chills _____ Night Sweats _____

Sweat easily _____ Tremors _____ Cravings _____ Bleed/Bruise easily _____ Weight loss _____

Weight gain _____ Localized weakness _____ Change in appetite _____

Peculiar tastes or smells _____ Strong thirst (prefer hot or cold drinks) _____

Sudden energy drop (what time of day)? _____

Skin and Hair: Please circle if applicable and rate the pain/occurrence from 1 to 10

Rashes _____ Ulcerations _____ Hives _____ Itching _____ Eczema _____ Pimples _____

Dandruff _____ Loss of hair _____ Recent moles _____ Change in hair or skin texture _____

Any other hair or skin problems? _____

Head, Eyes, Ears, Nose, and Throat: Please circle if applicable and rate the pain/occurrence from 1 to 10

Dizziness _____ Concussions _____ Migraines _____ Glasses _____ Eye strain _____ Eye pain _____

Poor vision _____ Night blindness _____ Color blindness _____ Cataracts _____ Blurry vision _____

Earaches _____ Poor hearing _____ Spots in front of eyes _____ Sinus problems _____

Nose bleeds _____ Recurrent sore throats _____ Grinding teeth _____ Facial pain _____ Jaw clicks _____

Sores on lips or tongue _____ Teeth problems _____

Any other head or neck problems? _____

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Cardiovascular: Please circle if applicable and rate the pain/occurrence from 1 to 10

High blood pressure _____ Low blood pressure _____ Chest pain _____ Irregular heartbeat _____

Dizziness _____ Fainting _____ Cold hands or feet _____ Swelling of hands _____ Swelling feet _____

Blood clots _____ Phlebitis _____ Difficulty in breathing _____

Any other heart or blood vessel problems? _____

Respiratory: Please circle if applicable and rate the pain/occurrence from 1 to 10

Cough _____ Coughing blood _____ Asthma _____ Bronchitis _____ Pneumonia _____

Pain in deep breath _____ Difficulty in breathing when lying down _____ Production of phlegm _____

Any other lung problems? _____

Comments: (problems you would like to discuss)



AcuWellness
Atlanta

WELCOME TO ACUWELLNESS ATLANTA

Dear AcuWellness Atlanta Patient,

In order to serve you better, we have found it necessary to implement the following policies. Please read carefully each section below and initial in the space provided.

Sign that you understand and agree. Thank you for your patronage. We truly appreciate you.

Yours in Health & Happiness,

Dr. Li Liu, L.Ac.

_____ Payment in full is due for services and products at the time of the appointment.

_____ Pre-Paid Packages are not transferable and may not be combined with any other special offers.

_____ A fee of \$25 may be assessed for appointments that are canceled less than 24 hours ahead of your time to appear. Others may be turned away in respect for that specific time scheduled for you.

_____ In light of unforeseen incidences causing delay, please call our office to let us know your anticipated time of arrival.

_____ ONLY the patient is allowed in the therapy room session.
(Unless approved by Dr. Liu)

_____ Questions regarding patient accounts MUST be directed to an Office Administrator during office hours.

_____ All sales are final, NO product or service package returns.

_____ We do not file insurance as we are a fee for service out of network clinic. We can give you a Superbill to file with your insurance company if they cover acupuncture.

I have read, I understand, and I agree with the above policies.

Signature: _____ Date: _____

Print Name: _____