SPARK HOLISTIC HEALTHCARE

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

NAME:_____DATE:_____
ADDRESS:_____CITY:_____STATE:_____ZIP: _____
HOME PHONE NUMBER:_____CELL:_____WORK:_____
EMAIL:_____
GENDER:_____DATE OF BIRTH:_____/_____/_____ AGE:_____ HEIGHT:_____WEIGHT:_____
MARITAL STATUS: _____NUMBER OF CHILDREN:_____OCCUPATION: _____

PHYSICIAN:_____PHONE: _____DATE OF LAST CHECKUP:_____
EMERGENCY CONTACT:_____PHONE NUMBER(S):_____

HAVE YOU RECEIVED ACUPUNCTURE BEFORE? _____WITH WHOM?_____
WHO CAN WE THANK FOR REFERRING YOU TODAY? _____

Reason for visit (symptoms, diagnosis, onset, duration, etc):

_____
_____
_____
_____
_____
_____
_____
_____

Please list any surgeries/hospitalizations (please include date of procedure):

_____
_____
_____
_____

Please list any medications you are currently taking including vitamins and supplements (names, dosages, etc.) :

Please check any that apply:

___I have a pacemaker ___ I am taking blood-thinning medication ___I am taking lithium ___I have a metal implant

Family Medical History

Please check any condition that applies to your immediate family.
Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to the choice.

❑ Diabetes_____ ❑ Seizures_____ ❑ Heart Disease_____ ❑ Stroke_____
❑ High Blood Pressure_____ ❑ Allergies_____ ❑ Cancer_____ ❑ Asthma_____
❑ Other_____

Please give a general description of your weekly diet (breakfast, lunch, dinner, snacks):

Any diet restrictions and/or food allergies? ___Yes ___No (if yes, please describe below)

Please indicate use and frequency (amount per week, day, or month) of the following:

Water_____Coffee/black tea_____ Tobacco_____

Soda_____Alcohol_____Recreational Drugs_____

Do you exercise? ___Yes ___No If yes, please describe type and frequency:

Personal History Please check any conditions or symptoms you have now.

- ❑ Arthritis
- ❑ High/Low Blood Pressure
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Thyroid Imbalance
- ❑ Lyme Disease
- ❑ Asthma
- ❑ Liver/Gall Bladder Disease
- ❑ Hypo/Hyperglycemia
- ❑ Food Allergies/Intolerance
- ❑ Raynaud's Disease
- ❑ Respiratory
- ❑ Chronic Pain Condition
- ❑ Infertility
- ❑ Stroke
- ❑ Kidney Disease
- ❑ Diverticulitis/IBS
- ❑ Chronic Fatigue
- ❑ Allergies
- ❑ Impotence
- ❑ Emphysema
- ❑ Heart Disease
- ❑ Cancer
- ❑ Ulcer Seizures
- ❑ Anemia
- ❑ Alcoholism
- ❑ Gastritis/Pancreatitis
- ❑ Elevated Blood Cholesterol

Please check any sign/symptom that is a current issue or has occurred within the past year.

General

- ❑ Poor Appetite
- ❑ Chills
- ❑ Cravings
- ❑ Weight loss/gain
- ❑ Strong thirst (hot or cold drinks)
- ❑ Poor sleeping
- ❑ Night sweats
- ❑ Localized weakness
- ❑ Peculiar tastes/smells
- ❑ Fatigue
- ❑ Sweats easily
- ❑ Poor balance
- ❑ Muscle weakness/fatigue
- ❑ Fevers
- ❑ Tremors
- ❑ Bleed/Bruise easily
- ❑ Sudden energy drop

Skin and Hair

- ❑ Rashes
- ❑ Eczema/Psoriasis
- ❑ Skin discoloration
- ❑ Warts
- ❑ Ulcerations
- ❑ Dandruff
- ❑ Acne
- ❑ Fungal Infection
- ❑ Hives/Allergic Dermatitis
- ❑ Loss of hair
- ❑ Change in skin/hair texture
- ❑ Weak or ridged nails
- ❑ Itching
- ❑ Recent moles
- ❑ Dermatitis

Head, Eyes, Ears, Nose and Throat

- ❑ Dizziness
- ❑ Eye pain
- ❑ Ringing in ears
- ❑ Nose bleeds
- ❑ Sores on lips/tongue
- ❑ Difficulty swallowing
- ❑ Poor vision
- ❑ Poor hearing
- ❑ Recurrent sore throats/colds
- ❑ Dental problems
- ❑ Migraines
- ❑ Blurred vision
- ❑ Spots in front of eyes
- ❑ Grinding teeth
- ❑ Jaw clicks/locks
- ❑ Glasses
- ❑ Earaches
- ❑ Sinus problems
- ❑ Facial pain
- ❑ Headaches

Cardiovascular

- ❑ Chest pain or pressure
- ❑ Cold hands/feet
- ❑ Shortness of breath
- ❑ Low blood pressure
- ❑ Irregular heart beat
- ❑ Swelling of hands/feet
- ❑ Varicose/spider veins
- ❑ Spontaneous sweating
- ❑ Palpitations at rest
- ❑ Blood clots
- ❑ Pressure in chest
- ❑ Dizziness
- ❑ Fainting
- ❑ Phlebitis
- ❑ High blood pressure

Respiratory

- ❑ Cough/Wheezing
- ❑ Pneumonia
- ❑ Difficulty breathing when lying down
- ❑ Coughing blood
- ❑ Pain with deep inhalation
- ❑ Asthma
- ❑ Tight sensation in chest
- ❑ Production of phlegm - what color?_____
- ❑ Bronchitis
- ❑ Difficult inhale/exhale

Gastrointestinal

- ❑ Nausea
- ❑ Gas
- ❑ Indigestion
- ❑ Bloating/Edema
- ❑ Hernia
- ❑ Vomiting
- ❑ Belching
- ❑ Bad breath
- ❑ Abdominal pain/cramps
- ❑ Significant thirst
- ❑ Diarrhea
- ❑ Black stools
- ❑ Rectal pain
- ❑ Changes in appetite
- ❑ IBS/Crohn's Disease
- ❑ Constipation
- ❑ Blood in stool
- ❑ Hemorrhoids
- ❑ Acid reflux/GERD

Genito-Urinary

- ❑ Pain on urination
- ❑ Unable to hold urine
- ❑ Burning urination
- ❑ Frequent urination
- ❑ Scanty flow
- ❑ Dribbling after urination
- ❑ Blood in urine
- ❑ Copious flow
- ❑ Night Urination Infections
- ❑ Urgent urination
- ❑ Urinary tract infection

Musculoskeletal

- ❑ Neck pain
- ❑ Knee pain
- ❑ Muscle pain
- ❑ Rotator Cuff
- ❑ Shoulder pain
- ❑ Sprains/Strains
- ❑ Muscle weakness
- ❑ Back pain Low___ Middle___ Upper___
- ❑ Hand/wrist pain
- ❑ Sciatica
- ❑ Tendonitis
- ❑ Carpal Tunnel
- ❑ Foot/ankle pain Hip pain
- ❑ Bursitis

Neuropsychological

- ❑ Seizures
- ❑ Lack of coordination
- ❑ Anxiety/Panic attacks
- ❑ Nervousness
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Bad temper/irritable
- ❑ ADD/ADHD
- ❑ Vertigo/Dizziness
- ❑ Concussion
- ❑ Easily susceptible to stress
- ❑ Manic Depression
- ❑ Areas of numbness
- ❑ Depression
- ❑ Seasonal Affective Disorder

Male

❑ Genital pain
❑ Impotence
❑ Low sexual energy
❑ Penis discharge
❑ Genital sores
❑ Lumps in testicles

Female

❑ Difficult/Painful intercourse
❑ Vaginal dryness
❑ Vaginal sores
❑ Vaginal discharge
❑ Infertility
❑ Irregular menstruation
❑ Low sexual energy
❑ Ovarian cysts
❑ Endometriosis
❑ Uterine Fibroids
❑ Fibrocystic breast tissue
❑ Polycystic Ovarian Disease
❑ Painful menstruation
❑ Age of first menses_____
❑ Date of last menses_____
❑ Date of last PAP/Pelvic_____
❑ Number of pregnancies____
❑ Number of ectopic pregnancies_____
❑ Number of live births_____
❑ Number of miscarriages_____

Irregular PAP? ❑ Yes ❑ No
Is your period regular? ❑ Yes ❑ No
If yes, date(s) and treatment_____
How long is your cycle?_____
How many days of flow?_____
Please describe any PMS signs/symptoms _____

_____

Do you practice birth control? ❑ Yes ❑ No
If yes, what type? _____
For how long? _____

How do you feel about the following areas of your life?
Please check the appropriate boxes, and indicate any problems you may be experiencing:

	Great	Good	Fair	Poor	Bad	Comments
Significant Other						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spirituality						

Please feel free to list/describe any other issues you would like to discuss:

_____

_____

I understand that Acupuncture does not replace doctor's care when needed. I will let my practitioner know if there are any changes in my health status. I understand that I will be charged fifty percent of the cost of my appointment if I do not cancel 24 hours before it is scheduled or do not show up or am more than 15 minutes late for my scheduled appointment.

Signature_____Date_____