Mandy Rose Acupuncture & Herbal Medicine
Health Questionnare

Date______________ Name____

Address____ City, State, Zip______________________

Age__________ Birthdate________________ Preferred Pronoun_________________________________

Phone/Cell_________________________ Email____

Occupation________________________________ Company Name______________________________

Healthcare Provider/Physician____

Emergency Contact_____________________________ Relationship____________________________

Phone/Cell/Email____

How did you hear about us?____

Have you had acupuncture before?__________ Sensitivity to needles?______________________

Most recent complete medical exam____

Reasons for today's visit:

1) ____

2) ____

3) ____

How is your sleep?____ Do you wake rested? Y N

How is your digestion?____

List medications or supplements you are taking____

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List serious illnesses, accidents, surgeries, and current medical treatments (pacemaker, chemotherapy, etc.)____

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Circle illnesses that have occurred in blood relatives: Alcoholism/Addiction Alzheimer's Autoimmune disease Cancer Diabetes Heart disease High blood pressure Kidney disease Mental illness Stroke

Circle symptoms you have or have had in the last year: Anxiety Depression Difficulty focusing Dizziness Easily startled Excessive anger or irritability Excessive fear Excessive worry Extreme stress Fatigue/Low energy Headaches Loss or gain of weight Loss of sleep/Poor sleep Mood swings Nervousness Over-thinking Overwhelmed by life Panic attacks Sadness/Grief Stress

Circle conditions you have or have had in the past: Anemia Autoimmune disease Bleeding disorders Breast lump Cancer Diabetes Hep B/C HIV/AIDS Seizure/Epilepsy Stroke Thyroid imbalance

Circle symptoms you have or have had in the last year:

Muscle/Joints/Bones: Arthritis Cramps/Spasms/Tremors Paralysis Scoliosis Sprain/Strain Swollen joints Tendonitis
Pain/Weakness/Numbness in: Arms or Hands Back or Hip Legs or Feet Jaw/TMJ Neck or Shoulders Other________________

Cardiovascular: Chest pain Cold hands or feet Hardening of the arteries Heart palpitations High or low blood pressure Previous heart attack Rapid/Irregular heartbeat Shortness of breath Swelling of ankles Varicose veins

Eyes/Ears/Head/Nose/Skin/Respiratory: Acne Allergies Asthma Bruise easily Blurred of failing vision Difficulty breathing Dry skin Earache Enlarged glands Eye pain Frequent colds Hay fever Itching or rashes Loss of hearing Nosebleeds Persistent cough Ringing in ears Sensitive skin Sinus problems Skin sores Sweats Wheezing

Gastrointestinal: Belching/Gas Bloating Constipation Diarrhea Difficulty swallowing Excessive hunger Gallbladder trouble Hemorrhoids Indigestion/Heartburn Loose stools Nausea Poor appetite Vomiting

Genito/Urinary: Bladder infection Blood/Pus in urine Frequent urination Inability to control urination Kidney infection Kidney stones Painful urination

Men: Erection difficulties Lowered libido Penis discharge Prostate trouble

Women: Bleeding between periods Clots in menses Cramps/PMS Excessive menstrual flow Extreme menstrual pain Fertility concerns IVF Hormone therapy Irregular cycle Lowered libido Menopausal symptoms Ovarian cyst Post-Menopause Previous miscarriage
Could you be pregnant? Y N **Birth Control:** ______________________________

The information on this form is correct to the best of my knowledge.

Signature____ **Date**__________________