On the following pages, you will find quite an extensive questionnaire. Compared to many medical disciplines, which are interested only in information pertaining to their specialty, in Oriental medicine, we look at your body as a system, having physical and emotional components. Having more complete information allows me to make a more complete diagnosis and give you a more comprehensive treatment.

Please fill out as much of the form as you feel comfortable with. If you do not feel comfortable disclosing any information, just skip that part. At our first meeting, we will go over the information you have provided together and you can ask any questions you may have before we begin. I realize that acupuncture is often new and unfamiliar and I welcome all questions, especially yours! Understanding and feeling comfortable with the treatment allows for a more effective result. If this is your first experience with acupuncture and Oriental medicine, I predict you will be pleasantly surprised.

Thank you for allowing Green Lotus to be part of your health care team.

Marcia Kirk, L.Ac.

Green Lotus Yoga & Healing Center
651.319.9525
marciak.acu@gmail.com
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# Acupuncture Patient Information

Name _____ Male Female

Address _____ Date of Birth_____

City _____ State _____Zip _____

Home Phone_____ Work Phone _____ Cell Phone _____

Email address _____

Best way to contact: _____Home _____Work _____Cell _____Email

Marital Status _____Single _____Married _____Widowed

Occupation _____ Employer/School _____

Emergency contact _____ Relationship _____ Phone _____

Primary physician _____Address or phone _____

How did you hear about us? _____

If referred by someone, who referred you to our office? _____

Main health concern(s) Please list in order of significance to you:

1. _____Date of onset _____
   Cause, if known _____
   What makes it better? _____
   What makes it worse? _____
   Past treatment _____

2. _____Date of onset _____
   Cause, if known _____
   What makes it better? _____
   What makes it worse? _____
   Past treatment _____

3. _____Date of onset _____
   Cause, if known _____
   What makes it better? _____
   What makes it worse? _____
   Past treatment _____

# Health History

Major illnesses _____

Significant traumas (Physical and/or emotional) _____

Surgeries/hospitalizations_____

Allergies and/or sensitivities to foods, drugs, environment, etc. (Please include your reaction)

_____

Occupational and other stressors _____

Height _____ Current Weight _____lb. Maximum Weight _____lb. When? _____

**Lifestyle**

Do you eat at least 3 meals a day? □ Yes □ No

Are your meals relaxed? □ Yes □ No

Do you eat while driving, working, etc.? □ Yes □ No

Drink caffeinated beverages? □ No □ Yes How much? _____

Describe your typical foods. _____

_____

Do you exercise regularly? □ Yes □ No

Describe the exercise you get _____

_____

Use Tobacco? □ Yes □ No How Long? _____ Packs per day? _____

Smoked Previously? □ Yes □ No When/for how Long? _____ Packs per day? _____

Drink Alcohol? □ Yes □ No How much? _____

Ever been treated for drug dependence? □ Yes □ No

**Family History:**

Please fill in the age and health information for family members, with a checkmark if they have an applicable history.

| **Condition** | Father | Mother | Brothers | Sisters | Child | Spouse |
|---|---|---|---|---|---|---|
| Health (G=good; P=poor) | | | | | | |
| Age, if living | | | | | | |
| If deceased, age at death | | | | | | |
| Cause of death | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Heart Disease | | | | | | |
| High Blood Pressure | | | | | | |
| Stroke | | | | | | |
| Epilepsy | | | | | | |
| Mental Illness | | | | | | |
| Asthma, hay fever, hives | | | | | | |
| Anemia | | | | | | |
| Kidney Disease | | | | | | |
| Glaucoma | | | | | | |
| Tuberculosis | | | | | | |

**Childhood Illnesses (Please circle):**

| | | |
|---|---|---|
| Scarlet Fever | Yes | No |
| Mumps | Yes | No |
| Chicken Pox | Yes | No |
| Diphtheria | Yes | No |
| Measles | Yes | No |
| Pneumatic fever | Yes | No |
| German Measles | Yes | No |

**Immunizations:**

| | | |
|---|---|---|
| Measles/Mumps/Rubella | Yes | No |
| Tetanus (Date_____) | Yes | No |
| Pertussis | Yes | No |
| Polio | Yes | No |
| Diphtheria | Yes | No |
| Hepatitis B | Yes | No |
| Influenza | Yes | No |
| Other | Yes | No |

**Allergies:**

Are you hypersensitive or allergic to:

Any Drugs? Yes No Please List:

_____

_____

Any Foods? Yes No Please List:

_____

_____

**Current Medications:**

Please list any prescription or over the counter medications, vitamins, or other supplements you are currently taking (use back of page if needed):

_____

_____

_____

_____

_____

## Symptom Profile:

For the following, please check **Now** for a condition you have **currently**, and check **Past** for a condition you've had in the past, noting the date in the space provided.

**Skin and Hair:**

| | Now | Past | When? |
|---|---|---|---|
| Acne, Boils | ☐ | ☐ | _____ |
| Acute Hair Loss | ☐ | ☐ | _____ |
| Color/texture Change | ☐ | ☐ | _____ |
| Eczema, Hives | ☐ | ☐ | _____ |
| Itching | ☐ | ☐ | _____ |
| Dandruff | ☐ | ☐ | _____ |
| Nail Fungus | ☐ | ☐ | _____ |
| Psoriasis | ☐ | ☐ | _____ |
| Rash | ☐ | ☐ | _____ |
| Other_____ | | | _____ |

**Respiratory System:**

| | Now | Past | When? |
|---|---|---|---|
| Asthma/Wheezing | ☐ | ☐ | _____ |
| Bronchitis | ☐ | ☐ | _____ |
| Chest Tightness | ☐ | ☐ | _____ |
| Chronic Asthma | ☐ | ☐ | _____ |
| Chronic Cough | ☐ | ☐ | _____ |
| Emphysema | ☐ | ☐ | _____ |
| Frequent Colds | ☐ | ☐ | _____ |
| Pain Breathing | ☐ | ☐ | _____ |
| Pneumonia | ☐ | ☐ | _____ |
| Shortness of Breath | ☐ | ☐ | _____ |
| Sinus Congestion | ☐ | ☐ | _____ |
| Spitting Up Blood | ☐ | ☐ | _____ |
| Temporary Cough | ☐ | ☐ | _____ |
| Tuberculosis | ☐ | ☐ | _____ |
| Other _____ | | | _____ |

**Musculoskeletal System:**

| | Now | Past | When? |
|---|---|---|---|
| Neck Pain | ☐ | ☐ | _____ |
| Shoulder Pain | ☐ | ☐ | _____ |
| Back Pain/Upper | ☐ | ☐ | _____ |
| Middle Back | ☐ | ☐ | _____ |
| Low Back | ☐ | ☐ | _____ |
| Hip Pain | ☐ | ☐ | _____ |
| Sciatica | ☐ | ☐ | _____ |
| Knee Pain | ☐ | ☐ | _____ |
| Other Joint Pain | ☐ | ☐ | _____ |
| Elbow Pain | ☐ | ☐ | _____ |
| Wrist Pain | ☐ | ☐ | _____ |
| Ankle Pain | ☐ | ☐ | _____ |
| Foot Pain | ☐ | ☐ | _____ |
| Arm Pain | ☐ | ☐ | _____ |
| Leg Pain | ☐ | ☐ | _____ |
| Rib Pain | ☐ | ☐ | _____ |
| Muscle Spasms/Cramps | ☐ | ☐ | _____ |
| Weakness | ☐ | ☐ | _____ |
| Location _____ | | | |
| Limited Use | ☐ | ☐ | _____ |
| Location _____ | | | |
| Limited Range of Motion | ☐ | ☐ | _____ |
| Location _____ | | | |
| Fibromyalgia | ☐ | ☐ | _____ |
| Broken Bones | ☐ | ☐ | _____ |
| Any Other Pain | ☐ | ☐ | _____ |
| Location: _____ | | | |
| Other _____ | ☐ | ☐ | _____ |

**Urinary Tract & Kidney Health:**

| | Now | Past | When? |
|---|---|---|---|
| Frequent Infection | ☐ | ☐ | _____ |
| Waking to urinate | ☐ | ☐ | _____ |
| Incontinence | ☐ | ☐ | _____ |
| Painful Urination | ☐ | ☐ | _____ |
| Urgent Urination | ☐ | ☐ | _____ |
| Blood in Urine | ☐ | ☐ | _____ |
| Kidney Stones | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ |

## Eye, Ear, Nose & Throat:

| | Now | Past | When? |
|---|---|---|---|
| Cataracts | ☐ | ☐ | _____ |
| Color Blindness | ☐ | ☐ | _____ |
| Contacts or Glasses | ☐ | ☐ | _____ |
| Double Vision | ☐ | ☐ | _____ |
| Eye Pain or Strain | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ |
| Impaired Vision | ☐ | ☐ | _____ |
| Tearing or Dryness | ☐ | ☐ | _____ |
| Spots in front of eyes | ☐ | ☐ | _____ |
| **Nose:** | | | |
| Nose Bleeds | ☐ | ☐ | _____ |
| Loss of Smell | ☐ | ☐ | _____ |
| Drainage to throat | ☐ | ☐ | _____ |
| Other_____ | ☐ | ☐ | _____ |
| **Mouth:** | | | |
| Bleeding Gums | ☐ | ☐ | _____ |
| Dental Cavities | ☐ | ☐ | _____ |
| Dry Mouth | ☐ | ☐ | _____ |
| Mouth Sores | ☐ | ☐ | _____ |
| Teeth Grinding | ☐ | ☐ | _____ |
| Jaw Problems, TMJ | ☐ | ☐ | _____ |
| **Throat**: | | | |
| Goiter | ☐ | ☐ | _____ |
| Hoarseness | ☐ | ☐ | _____ |
| Swollen Glands | ☐ | ☐ | _____ |
| Trouble Swallowing | ☐ | ☐ | _____ |
| Neck Pain/ Stiffness | ☐ | ☐ | _____ |
| Frequent Sore Throat | ☐ | ☐ | _____ |
| Feel lump in throat | ☐ | ☐ | _____ |

## Cardiovascular System:

| | Now | Past | When? |
|---|---|---|---|
| Heart Disease | ☐ | ☐ | _____ |
| Chest Pain | ☐ | ☐ | _____ |
| Heart Murmur | ☐ | ☐ | _____ |
| Palpitations/Fluttering | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | _____ |
| Low Blood Pressure | ☐ | ☐ | _____ |
| Irregular Heartbeat | ☐ | ☐ | _____ |
| Tachycardia | ☐ | ☐ | _____ |
| Phlebitis | ☐ | ☐ | _____ |
| Blood Clots | ☐ | ☐ | _____ |
| Ankle Swelling | ☐ | ☐ | _____ |
| Fainting | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ |

## Digestive System

| | Now | Past | When? |
|---|---|---|---|
| Nausea | ☐ | ☐ | _____ |
| Vomiting | ☐ | ☐ | _____ |
| Loss of Appetite | ☐ | ☐ | _____ |
| Ulcer | ☐ | ☐ | _____ |
| Heartburn | ☐ | ☐ | _____ |
| Bad Breath | ☐ | ☐ | _____ |
| Gas or Bloating | ☐ | ☐ | _____ |
| Internal Cramping | ☐ | ☐ | _____ |
| Constipation | ☐ | ☐ | _____ |
| Diarrhea | ☐ | ☐ | _____ |
| Loose Stool | ☐ | ☐ | _____ |
| Rectal itching/burning | ☐ | ☐ | _____ |
| Hemorrhoids | ☐ | ☐ | _____ |
| Bowel Movement Frequency | | | _____ |
| - Is this a change? | | | _____ |
| Other _____ | | | _____ |

## Emotional or Mental Health:

| | Now | Past | When? |
|---|---|---|---|
| Anxiety | ☐ | ☐ | _____ |
| ADD or ADHD | ☐ | ☐ | _____ |
| Depression | ☐ | ☐ | _____ |
| Highly stressed | ☐ | ☐ | _____ |
| Considered or Attempted Suicide | ☐ | ☐ | _____ |
| Irritability | ☐ | ☐ | _____ |
| Poor memory | ☐ | ☐ | _____ |
| Mood Swings | ☐ | ☐ | _____ |
| Abuse survivor | ☐ | ☐ | _____ |
| Seeing a therapist | ☐ | ☐ | _____ |
| Other _____ | | | _____ |

Please describe other health history or concerns not listed above: