



# Christina Wolf Acupuncture

Natural Treatments for Pain Management, Women's Health and Fertility

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## Health History Questionnaire – Acupuncture & Asian Medicine Center of Peterborough

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone #s Home: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

In Emergency Notify: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about my office? \_\_\_\_\_

What is the main problem you would like to address with acupuncture? \_\_\_\_\_

How long ago did this problem begin (be as specific as possible)? \_\_\_\_\_

To what extent does this problem interfere with your daily activities? \_\_\_\_\_

What other kinds of treatments have you tried? \_\_\_\_\_

Have you consulted with your primary care physician? \_\_\_\_\_

If Yes, did he/she give you a Western medical diagnosis\*? \_\_\_\_\_

Please list any medications, herbs or supplements you are currently taking for this condition: \_\_\_\_\_

Please make a check mark next to symptoms you currently experience or have experienced within 6 months:

### Body Temperature

- \_\_\_ Always Cold
- \_\_\_ Always Hot
- \_\_\_ Hands & Feet Cold
- \_\_\_ Sweating at night
- \_\_\_ Sweating without exertion

### Skin/Hair

- \_\_\_ Psoriasis
- \_\_\_ Eczema
- \_\_\_ Hives
- \_\_\_ Other rash
- \_\_\_ Dryness
- \_\_\_ Recently thinning/losing hair

### Head/Face

- \_\_\_ Migraines
- \_\_\_ Frequent headaches
- \_\_\_ Dizziness
- \_\_\_ Poor memory
- \_\_\_ Head feels “cloudy” or “heavy”
- \_\_\_ Facial paralysis

**Eyes**

- Blurring of vision
- Floaters
- Watery eyes
- Dry eyes
- Itchy & irritated eyes
- Blindness

**Respiratory**

- Shortness of breath
- Cough
- Chronic bronchitis
- Asthma
- Emphysema
- Lung cancer

**Digestion**

- Heartburn
- Chronic gas
- Nausea
- Vomiting
- Abdominal Pain
- Cramping
- History of gall stones

**Sleep**

- Difficulty falling asleep
- Waking frequently
- Nightmares
- Snoring
- Muscle cramps

**Ears**

- Ringing in ears
- Loss of hearing
- Ear infections
- Congestion
- Dizziness (related to ears)

**Cardiovascular**

- Pain in chest
- Tightness in chest
- Heart palpitations
- Irregular heart rhythm
- High blood pressure
- High cholesterol
- Hardening of arteries

**Stools**

- Diarrhea
- Constipation
- Blood in stool
- Mucous in stool
- Irritable Bowel
- Colitis

**Energy Level**

- Fatigue
- Difficulty waking
- Heavy limbs
- Feeling sleepy
- Too much energy
- Restlessness

**Nose/Throat**

- Allergies
- Sinus infections
- Sinus headaches
- Trouble swallowing
- Sensation of "lump in throat"
- Chronic laryngitis

**Appetite/Thirst**

- Increased appetite
- Decreased appetite
- Crave sweet taste
- Crave sour taste
- Crave salty taste
- Thirsty
- No thirst

**Urination**

- Increased frequency
- Pain or burning on urination
- Waking to urinate at night
- Incontinence or leaking
- Difficulty urinating
- History of frequent infection
- History of kidney stones

**Muscles & Joints**

- Arthritis in \_\_\_\_\_
- Bursitis in \_\_\_\_\_
- Tendinitis in \_\_\_\_\_
- Stiff or tight muscles
- Sciatica
- Neck pain
- Low back pain

**OB/GYN**

- Irregular Periods
- Heavy Periods
- Light Periods
- PMS
- Cramping
- Endometriosis
- Ovarian Cysts
- Uterine Fibroids
- Sexually transmitted disease

**Fertility**

- Irregular Ovulation
- Miscarriage
- Stillbirth
- # of pregnancies
- # of children
- # of abortions
- Other

**Other (symptoms not listed above):**

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**Mental Health**

- Anxiety
- Panic Attacks
- Depression
- Bipolar Disorder
- Seasonal Affective Disorder
- Phobias
- Other

**Please indicate the extent to which the following emotions are problematic or lacking for you:**

- |  |      |      |      |
|--|------|------|------|
| <input type="checkbox"/> Grief & Sadness     | None | Some | Alot |
| <input type="checkbox"/> Joy & Excitement    | None | Some | Alot |
| <input type="checkbox"/> Anger & Frustration | None | Some | Alot |
| <input type="checkbox"/> Fear                | None | Some | Alot |
| <input type="checkbox"/> Worry               | None | Some | Alot |

Please indicate if anyone in your immediate family has or has a history of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Diabetes      |   |
| <input type="checkbox"/> Cancer        |   |
| <input type="checkbox"/> Seizures      |   |

Please list the dates and reasons for any hospitalizations or surgeries:

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Please list any other medications, supplements or herbs that your are currently taking:

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How many packs of cigarettes do you smoke per week?

How much coffee, tea or cola do you drink per week?

How much alcohol do you drink per week?

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

Do you have a regular exercise program?

Please describe:

Please describe any other problems you would like to discuss or address with acupuncture: