

Deborah Earley, M. Ac., L. Ac., Dipl. Ac

P Street Wellness

2000 P Street, Suite 720

Washington, D.C. 20036

240-603-7272

www.EarleyAcupuncture.com

Your Health History

Please take a moment to complete the attached questionnaire. Your effort is greatly appreciated and will make an important contribution to your overall health care.

Name: _____

Address: _____

Phone (h) _____ (c) _____ (w) _____

Date of Birth _____ Age _____ Email _____

Occupation _____ Employer _____

Relationship Status (optional)

Single _____ Married _____ Partnered _____ Divorced _____ Separated _____ Widowed _____

Persons in household and how they relate to you: _____

Does anything limit you from care? (yes __) (No) Explain _____

What concerns would you like to address in your acupuncture treatments? How long have you had the condition(s)? What Kind(s) of treatment have you tried?

What type(s) of health related issues, hospitalizations, and surgeries have you had in the past?

Year/Condition _____

Year/Condition _____

Year/Condition _____

Medications: List all current over-the-counter & prescription medications, herbs, and vitamins

Name	Dose/amount	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the types of foods you eat: _____

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Snacks & times eaten: _____

What foods do you crave? _____

Do you exercise regularly? Yes ____ No ____

Type of Exercise	How often?	How long?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Habits:

Do you smoke? Y N How much a day? _____ Since _____

Do you take recreational drugs? Y N What Kind? _____

How many hours do you sleep in general? _____ Do you feel rested when you wake? _____

Diet: How much caffeine do you drink a day (include: coffee, tea, colas, & energy drinks)? _____

What kind of alcohol do you usually drink? _____ Avg. # of drinks per week: _____

How much water do you drink per day? _____

Please rate on a scale of 1-10 (1=worst & 10=best):

Your relationship with your health ____ Your relationship with your work ____

Your relationship with yourself ____ Your relationship with other ____

Your interest in lifestyle advice ____

Please check any of the following that apply to you:

Contributing factors to lack of personal optimum health:

____Lack of motivation ____Lack of information

____Lack of time ____Contradictory information

____Inability to follow through ____Circumstances

Areas that you feel could be improved in your life:

____Diet ____Physical activity ____Time management ____Priorities ____Outlook

Other: _____

Please check if you have or have had any of the following conditions within the past 3 months:

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Poor balance | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar taste | <input type="checkbox"/> Desire hot food | <input type="checkbox"/> Desire cold food | <input type="checkbox"/> Strong thirst
(hot/cold) | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> time of day | Favorite season _____ | | Least favorite season _____ | |

Skin & Hair:

- | | | | | |
|----------------------------------|--------------------------------------|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Change in hair or skin
texture |
- Other: _____

Musculoskeletal:

- | | | | | |
|--|--|---|---|-----------------------------------|
| <input type="checkbox"/> Joint disorders | <input type="checkbox"/> Weakness in muscles | <input type="checkbox"/> Pain/Soreness in muscles | | |
| <input type="checkbox"/> Difficult walking | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cold hand/feet | <input type="checkbox"/> Swelling of hands/feet | |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Spinal curvature | <input type="checkbox"/> Hernia | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Neck tightness | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand /wrist pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprain of joint | Other: _____ | | |

Head, Eyes, Ears, & Throat:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses/lens | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Blurry eye vision | <input type="checkbox"/> Earaches | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Nose bleeding | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Jaw clicks | <input type="checkbox"/> Sores on lips/tongues | <input type="checkbox"/> Difficulty swallowing | |
- Other: _____

Cardiovascular

- | | | | | |
|---|---|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Varicose veins | Other: _____ | |

Respiratory

- | | | | | |
|------------------------------------|---|---|--|-------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Difficulty in breathing | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Production of phlegm-what color? _____ | Other: _____ | |

Gastrointestinal

Bowel movements: Frequency_____ ___ Loose Stool ___ Well Formed ___ Constipation

___ Fluxuate between loose and constipated Other: _____

___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Gas

___ Belching ___ Black stools ___ Blood in stools ___ Indigestion ___ Bad breath

___ Rectal pain ___ Hemorrhoid ___ Abdominal cramp/pain ___ Gallbladder problem ___ Parasites

___ Chronic laxative use

Neuro-psychological

___ Loss of balance ___ Lack of coordination ___ Concussion ___ Depression ___ Anxiety

___ Stress ___ Bad temper ___ Bi-polar Other: _____

Genitourinary

___ Pain on urination ___ Frequent urination ___ Blood in urine ___ Urgency to urinate ___ Kidney stones

___ Unable to hold urine ___ Dribbling ___ Pause in flow ___ Frequent urinary tract infections

___ Pain in genitals ___ Itching of genitals Other: _____

Female

___ Frequent vaginal infections ___ Pelvic infection ___ Endometriosis ___ Vaginal discharge ___ Fibroids

___ Ovarian cysts ___ Irregular periods ___ Clots ___ Pain/cramps prior/during period

___ Breast tenderness ___ Breast lumps ___ Fertility problems ___ Moodiness relate to periods

___ Low libido ___ Hot flashes ___ Vaginal dryness Other: _____

of pregnancies_____ #of births_____ Miscarriages_____ Abortions_____ Premature births_____

___ Sexually active ___ Use contraception ___ Sexually transmitted infection ___ Sexually satisfied ___ Sexual trauma

Male

___ Prostate problems ___ Discharge ___ Impotence ___ Frequent seminal emission

___ Fertility problems ___ Ejaculation problems ___ Painful/swollen testicles ___ Low Libido ___ Hot Flashes

___ Sexually active ___ Use contraception ___ Sexually transmitted Infection ___ Sexually satisfied ___ Sexual trauma

Other: _____