STREAM POINT Acupuncture

Stream Point Acupuncture
Hardin Field V C.Ac.
859.492.3028
Info@StreamPointAcupuncture.com
www.StreamPointAcupuncture.com

This is a **confidential** questionnaire to help determine the best treatment plan for you. If you have questions, please ask. Thank you.

PERSONAL INFORMATION

Name (First)____________________ (Last) ____________________ Date ______________

Address ____

City ____________________ State ____________________ zip ______________

Phone ____________________ E-mail ____________________

Occupation ____________________ Person Responsible for your account ____________________

Emergency Contact: Name ____________________ Phone ____________________

Who should we thank for referring you to this office? ____________________

Sex: ❑ Male ❑ Female ❑ Trans________ MTF _____ FTM Height _________ Weight ________ Birth date___________ Age ______

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Partnered Number of children ______________

Have you received acupuncture therapy before? ❑ Yes ❑ No

When? ____________________ With Whom? ____________________

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	❑	❑	________	Diabetes	❑	❑	________
Hepatitis	❑	❑	________	Heart Disease	❑	❑	________
High Blood Pressure	❑	❑	________	Seizures	❑	❑	________
Rheumatic Fever	❑	❑	________	Emotional Disorders	❑	❑	________
Infectious Diseases	❑	❑	________	Tuberculosis	❑	❑	________

Sexually Transmitted Diseases: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ HPV ❑ Chlamydia ❑ Herpes Date ______________

List any medications and supplements your are currently taking: (Continue on back if necessary.)

Medicine ____________________ Dosage ____________________ Reason ____________________

How long ____________________ Prescribed by ______________ Date of last checkup ____________________

Check the Box if any of the following statements are true:

❑ I have known allergies
❑ I am taking Coumadin/warfarin
❑ I have a pacemaker
❑ I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee/black tea	❑	❑	________	Tobacco	❑	❑	________
Non-medical drugs	❑	❑	________	Water Intake	❑	❑	________
Alcohol	❑	❑	________	Soda pop	❑	❑	________

OB/GYN HISTORY (Women Only)

Age of 1st period (menarche) ______________ Are you pregnant? ❑ Yes ❑ No # of Pregnancies ______

Age of last period (menopause) ____________ # of Live Births_____ # Abortions ______ # of Miscarriages ______

Number of days between periods ___________ Date of last gynecologic exam __________

Number of days of flow __________________ Mammogram _______________ Bone Density Scan _______________

Color of flow ____________________________ Results ____

Clots? ❑ Yes ❑ No Color _______

Average number of pads you use per day: 1st day_____ 2nd day______ 3rd day _____ 4th day ______ + days______

Location of Pain: ❑ Lower Abdomen ❑ Lower back ❑ Thighs ❑ Other

Nature of Pain (Please indicate before, during or after menses)

Cramping _________________ Stabbing________________

Burning ___________________ Aching _________________

Dull ______________________ Bloating ________________

Consistent_________________ intermittent _____________

Bearing down sensation _____________________________

Other Symptoms related to menses:

❑ Discharge ❑ Nausea ❑ Vaginal dryness

❑ Constipation ❑ Headache ❑ Diarrhea

❑ Ravenous appetite ❑ Night sweats ❑ insomnia

❑ Swollen breasts ❑ Mood swings ❑ Poor appetite

❑ Hot flashes ❑ increased libido ❑ Decreased libido

UROGENITAL HISTORY (Men Only)

Date of last prostate check up __________________ PSA results________________ Manual prostate exam results _________________________

Lab results____

Frequency of Urination: Daytime_________ Nighttime__________ Color of Urine: ❑ Clear ❑ Murky Odor: _______________

Symptoms related to prostate:

❑ Prostate Problems ❑ Delayed Stream ❑ Post Void Dribbling ❑ Incontinence ❑ Retention Of Urine

❑ Erectile Dysfunction (Ed) ❑ Increased Libido ❑ Decreased Libido ❑ Premature Ejaculation ❑ Impotence

❑ Back Pain ❑ Groin Pain ❑ Testicular Pain ❑ Decreased Force Of Stream ❑ BPH/Enlarged Prostate

❑ Other

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark ( ) = never experience. Check mark (✓) = Sometimes experience. Plus sign (+) = Frequently experience.

___Lack of appetite
___Excessive appetite
___Loose stool or diarrhea
___digestive problems,
___indigestion
___vomiting
___belching, burping
___heartburn/reflux
___feeling the retention of
___food in the stomach
___tendency to become
___obsessive in work or relationships
___insomnia, difficulty sleeping
___heart palpitations
___cold hands and feet

___nightmares
___mentally restless
___laughing for no apparent reason
___angina pains
___abdominal pain
___chest pain
___sciatic pain
___headaches
___pain or coldness in the genital area
___cough
___shortness of breath
___decreased sense of smell
___nasal problems
___skin problems

___feeling of claustrophobia
___bronchitis
___colitis or
___diveniculitis
___constipation
___hemorrhoids
___recent use of antibiotics
___eye problems
___jaundice (yellowish eyes or skin
___difficulty digesting oily foods
___gall stones
___light colored stool
___soft or brittle nails
___easily angered or agitated

___difficulty in making plans or decisions
___spasms or twitching of muscles
___low back pain
___knee problems
___hearing impairment
___ear ringing
___kidney stones
___decreased sex drive
___hair loss
___urinary problems
___fatigue
___edema
___blood in stool
___black tarry stool

___easily bruised
___difficult to stop bleeding
___asthma
___tendency to catch colds easily
___intolerance to weather changes
___allergies
___hav fever
___dizziness
___tendency to faint easily
___high cholesterol levels
___sudden weight loss

What are the main health problems for which your are seeking treatment?

____

____

What other forms of treatment have you sought?

____

____

List any other health problems you now have.

____

____

List any allergies, food sensitivities or food craving that you have.

____

____

List any accidents, surgeries, or hospitalizations (include date).

____

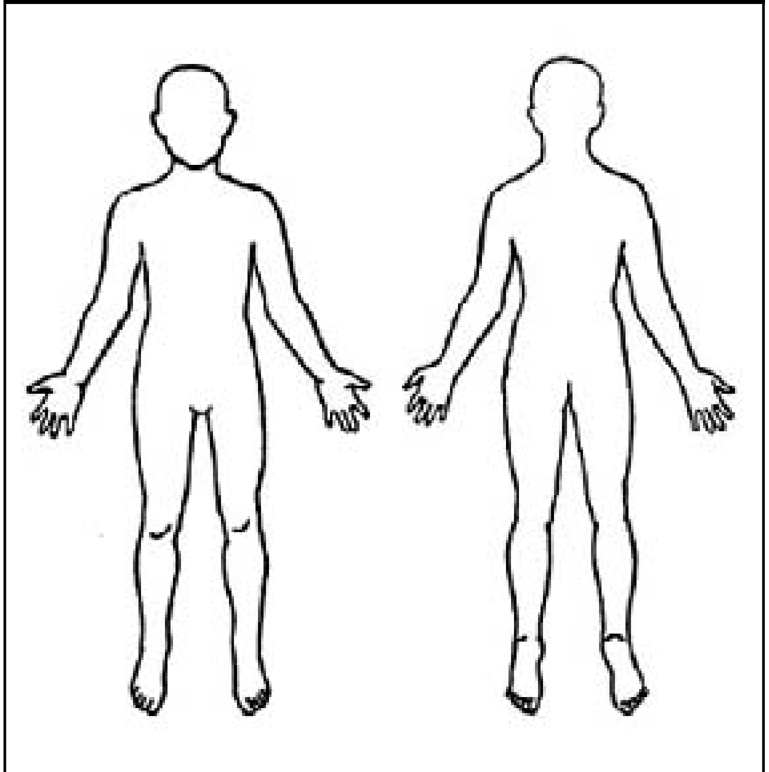
____

Lab Results: (please include copies)

____

____

Please identify current problem areas in your body by marking or shading in the appropriate areas on the diagrams.



Please mark if you are currently experiencing any of the following conditions

❑Hypertension and cardiac conditions ❑Acute, severe abdominal pain ❑Undiagnosed neurological changes ❑Unexplained weight loss or gain ❑Suspected fracture or dislocation ❑Suspected systemic infections ❑Serious hemorrhagic disorder ❑Acute respiratory distress ❑Diabetes ❑Cancer

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	Your Comments
Significant Other	❑	❑	❑	❑	❑	______________
Family	❑	❑	❑	❑	❑	______________
Diet	❑	❑	❑	❑	❑	______________
Sex	❑	❑	❑	❑	❑	______________
Self	❑	❑	❑	❑	❑	______________
Work	❑	❑	❑	❑	❑	______________
Exercise	❑	❑	❑	❑	❑	______________
Spirituality	❑	❑	❑	❑	❑	______________

Other information you would like to report / may be relevant to your medical history?

____

____

____

____

____