Amorah Kelly, L.Ac.

Wonderworks Healing Arts

Traditional Oriental Medicine

Acupuncture

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

Personal Information

Name _____ Date _____

Home Address _____ e-mail _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Occupation _____ Person Responsible for your account _____

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

Sex: ☐ Male ☐ Female Height _____ Weight _____ Birthdate _____ Age _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed 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 ☐AIDS ☐HPV ☐Chlamydia ☐Herpes Date _____

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last check-up

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee/black tea	☐	☐	_____	Tobacco	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical drugs	☐	☐	_____	Alcohol	☐	☐	_____	Soda Pop	☐	☐	_____

What are the main health problems for which you 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)

Clinical Notes

(Intern's Use)

HPI:

☐ Onset ☐ Location ☐ Duration ☐Characteristics

☐ Aggravate/Allev ☐ Related Factors ☐ Treatment ☐Significance

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	☐	☐	☐	☐	☐	

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No # of pregnancies

Age of last period (menopause) _____ # of live births _____ # of Abortions _____ # of Miscarriages _____

Number of days between periods _____ Date of last: Gynecologic exam _____ Pap Smear _____

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: ____

Have you ever been diagnosed with: ☐Fibroids ☐Fibrocystic Breasts ☐Endometriosis ☐Ovarian Cysts ☐PID ☐Other

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

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

Cramping	_____	Stabbing	_____	☐ Discharge	☐ Vaginal Dryness	☐ Headache
Burning	_____	Aching	_____	☐ Nausea	☐ Constipation	☐ Diarrhea
Dull	_____	Bloating	_____	☐ Swollen Breasts	☐ Mood swings	☐ Ravenous appetite
Consistent	_____	Intermittent	_____	☐ Poor appetite	☐ Hot flashes	☐ Night Sweats
Bearing down sensation	_____			☐ Increased Libido	☐ Decreased libido	☐ Insomnia

Other Symptoms related to menses

For Men

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	☐ Dribbling	☐ Incontinence	☐ Retention of Urine
☐ Rectal dysfunction	☐ Increased libido	☐ Decreased libido	☐ Premature Ejaculation	☐ Impotence
☐ Back pain	☐ Groin pain	☐ Testicular pain	Other _____	

Symptom Survey (For Everyone)

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

___ Lack of appetite	___ Abdominal pain	___ Eye problems	___ Fatigue
___ Excessive appetite	___ Chest pain	___ Jaundice (yellowish eyes/skin)	___ Edema
___ Loose Stool or diarrhea	___ Sciatic pain	___ Difficulty digesting oily foods	___ Blood in stool
___ Digestive problems, indigestion	___ Headaches	___ Gall stones	___ Black tarry stool
___ Vomiting	___ Pain or coldness in the genital area	___ Light colored stool	___ Easily bruised
___ Belching, burping	----------	___ Soft or brittle nails	___ Difficult to stop bleeding
___ Heartburn/reflux	___ Cough	___ Easily angered or agitated	___ Asthma
___ Feeling the retention of food in the stomach	___ Shortness of breath	___ Difficulty in making plans or decisions	___ Tendency to catch colds easily
___ Tendency to become obsessive in work/personal	___ Decreased sense of smell	___ Spasms or twitching of muscles	___ Intolerance to weather changes
----------	___ Nasal problems	----------	___ Allergies
___ Insomnia, difficulty sleeping	___ Skin problems	___ Low back pain	___ Hay Fever
___ Heart palpitations	___ Feeling of claustrophobia	___ Knee problems	___ Dizziness
___ Cold hands and feet	___ Bronchitis	___ Hearing impairment	___ Tendency to faint easily
___ Nightmares	___ Colitis or diverticulitis	___ Ear ringing	___ High cholesterol levels
___ Mentally restless	___ Constipation	___ Kidney stones	___ Sudden weight loss
___ Laughing for no apparent reason	___ Hemorrhoids	___ Decreased sex drive	
	___ Recent use of antibiotics	___ Hair loss	
___ Angina pains		___ Urinary problems	