BOWEN CHIROPRACTIC AND WELLNESS CENTER
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Here is some advice to get the most benefit from your acupuncture treatments and to avoid side effects.

Before you come for your acupuncture visit:

- Bring a list of all medications and supplements you are taking.
- Wear no make-up or perfume, especially on your first visit.
- Loose clothing is more convenient. We ask the patient to undress if the painful area is difficult to access otherwise.
- Do not drink coffee at least 5 hours prior to your visit.
- Have a light meal or snack before the visit. Heavy meals can cause nausea. Empty stomach can be the cause of dizziness after the treatment.
- Drink enough water on the day of the treatment.
- Do not eat or drink food that changes the color of your tongue.
- Do not drink alcohol.

After your acupuncture visit:

- Do not drink alcohol.
- Do not eat greasy or spicy food.
- Rest is preferable. Make the day as easy as possible.
- Do not exercise.
- Do not shower.

Acupuncture

Health History Questionnaire

This information is for your Acupuncturist. Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in your diagnosis and treatment.

All information is strictly confidential.

Patient Name: _____ Date: _____

Address: _____City: _____

State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____/_____/_____ Age: _____

Email Address: _____ Gender: _____

Marital Status: Single _____ Married _____ Divorced _____ Widower _____

Legal Guardian (if under 18) _____

Emergency Contact: _____ Phone: _____

Social Security Number: _____/_____/_____

I authorize the listed person (or persons) to be informed of my Protected Health Information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

How did you hear about our office: _____

Occupation: _____ Employer: _____

Employer Address: _____

Does anything limit you from care? Yes _____ No _____ If yes, please explain:

_____

Current Medications: _____

_____

Supplements (any vitamins, herbs, minerals, etc.): _____

_____

Results: _____

_____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	❑	❑	❑	❑	_____
2.	❑	❑	❑	❑	_____
3.	❑	❑	❑	❑	_____
4.	❑	❑	❑	❑	_____
5.	❑	❑	❑	❑	_____
6.	❑	❑	❑	❑	_____
7.	❑	❑	❑	❑	_____
8.	❑	❑	❑	❑	_____
9.	❑	❑	❑	❑	_____
10.	❑	❑	❑	❑	_____

How do these conditions impair your daily activities?_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

Recent tests: (please indicate test results and date below)

❑ Physical ❑ Cholesterol ❑ Prostate ❑ Blood (which?)

❑ HIV/STD ❑ Pap smear ❑ Mammography

❑ Other:_____

Test Results and Date:_____

Check any you have had in the past:

❑ Diabetes	❑ Allergies	❑ Glaucoma	❑ Rheumatic Fever
❑ Heart Disease	❑ CVA (stroke)	❑ Vein condition	❑ Thyroid disorder
❑ Asthma	❑ Pneumonia	❑ Tuberculosis	❑ Emphysema
❑ Jaundice	❑ Gonorrhea	❑ Mumps	❑ Bleeding tendency
❑ Syphilis	❑ Measles	❑ Chicken pox	❑ Nervous disorder
❑ Meningitis	❑ HIV	❑ Polio	❑ Mononucleosis
❑ Epilepsy	❑ High fever	❑ Hepatitis	❑ Multiple Sclerosis
❑ Paralysis	❑ Cancer	❑ Migraines	❑ High blood pressure
❑ other lung illnesses	❑ other liver illnesses	❑ other heart illnesses	❑ other kidney illnesses
❑ other spleen illnesses		❑ other stomach illnesses	

❑ other:_____

Immunizations:_____

Surgeries:_____

III. Family History

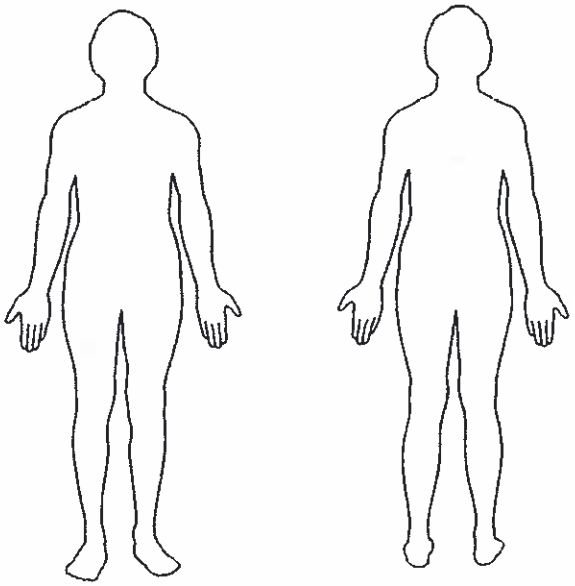
Family member	Alive	Deceased	Present health or cause of death
Father	❑	❑	
Mother	❑	❑	
Spouse	❑	❑	
Children	❑	❑	
Brother	❑	❑	
Brother	❑	❑	
Brother	❑	❑	
Sister	❑	❑	
Sister	❑	❑	
Sister	❑	❑	

Where are you in the birth order? ❑ first ❑ last ❑ middle ❑ only
Check the following that have occurred in your blood relatives:

❑ Diabetes	❑ Cancer	❑ Heart disease	❑ High blood pressure
❑ Allergies	❑ Tuberculosis	❑ Obesity	❑ Bleeding tendency
❑ Kidney disease	❑ Alcoholism	❑ Nervous Illness	❑ Mental illness
❑ Stroke	❑ Other_____		

IV. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Front Back

Is the pain:
❑ Sharp ❑ Burning ❑ Aching
❑ Cramping ❑ Dull ❑ Moving
❑ Fixed ❑ Other:_____

Do the following lessen the pain?
❑ Pressure ❑ Cold ❑ Heat
❑ Exercise ❑ Other:_____

Do the following worsen the pain?
❑ Pressure ❑ Cold ❑ Heat
❑ Other:_____

Please check the following that pertain to you:

Overall Temperature (Kidney function):
❑ Cold hands
❑ Cold feet
❑ Sweaty hands
❑ Sweaty feet
❑ Hot body temperature (sensation)
❑ Cold body temperature (sensation)
❑ Afternoon flushes
❑ Night sweats
❑ Heat in the hands, feet, and chest
❑ Hot flashes any time of the day
❑ Thirsty
❑ Perspire easily
❑ Lack of perspiration

❑ Take water to bed
❑ Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney function):
❑ Shortness of breath
❑ Difficulty keeping eyes open in the daytime
❑ General weakness
❑ Easily catch colds
❑ Low energy
❑ Feel worse after exercise

Blood (Liver, Spleen, Heart function):
❑ Dizziness
❑ See floating black spots

Heart function:
❑ Palpitations
❑ Anxiety
❑ Sores on the tip of the tongue
❑ Restlessness
❑ Mental confusion
❑ Chest pain traveling to shoulder
❑ Frequent dreams
❑ Wake unrefreshed
❑ Drink coffee (# of cups per week: _____)

Lung function:
❑ Nasal Discharge (Color: _____)
❑ Cough
❑ Nose Bleeds
❑ Sinus Congestion
❑ Dry mouth
❑ Dry throat
❑ Dry Nose
❑ Dry Skin
❑ Allergies (To what?_____)
❑ Alternating fever and chills
❑ Sneezing
❑ Headache (Location: _____)
❑ Overall achy feeling in the body
❑ Stiff neck
❑ Stiff shoulders
❑ Sore throat
❑ Difficulty breathing
❑ Smoke cigarettes (# of cigarettes per day: _____)
❑ Sadness
❑ Melancholy

Spleen function:
❑ Low appetite
❑ Abrupt weight gain
❑ Abrupt weight loss
❑ Abdominal bloating
❑ Abdominal gas
❑ Gurgling noise in the stomach
❑ Fatigue after eating
❑ Prolapsed organs (previously diagnosed, which organ? _____)
❑ Easily bruised
❑ Hemorrhoids
❑ Pensive
❑ Over-thinking
❑ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:
❑ Loose
❑ Constipated
❑ Incomplete
❑ Diarrhea
❑ Blood in stools
❑ Mucous in stools
❑ Undigested food in stools

Dampness trapped in the body:
❑ General sensation of heaviness in the body
❑ Mental heaviness
❑ Mental sluggishness
❑ Mental fogginess

- ❑ Swollen hands
- ❑ Swollen feet
- ❑ Swollen joints
- ❑ Chest congestion
- ❑ Nausea
- ❑ Snoring

Stomach function:

- ❑ Burning sensation after eating
- ❑ Large appetite
- ❑ Bad breath
- ❑ Mouth (canker) sores
- ❑ Bleeding, swollen or painful gums
- ❑ Heartburn
- ❑ Acid regurgitation
- ❑ Ulcer (diagnosed)
- ❑ Belching
- ❑ Hiccoughs
- ❑ Stomach pain
- ❑ Vomiting

Liver, Gall Bladder function:

- ❑ Alternating diarrhea and constipation
- ❑ Chest pain
- ❑ Tight sensation in the chest
- ❑ Bitter taste in the mouth
- ❑ Anger easily
- ❑ Frustration
- ❑ Depression
- ❑ Irritability
- ❑ Frequently unable to adapt to stress (What causes the stress? _____)
- ❑ Skin rashes
- ❑ Headache at the top of the head
- ❑ Tingling sensation
- ❑ Numbness
- ❑ Muscle spasms
- ❑ Muscle twitching
- ❑ Muscle cramping
- ❑ Seizures
- ❑ Convulsions
- ❑ Lump in the throat
- ❑ Neck tension
- ❑ Limited Range-of-Motion, Neck
- ❑ Shoulder tension
- ❑ Limited Range-of-Motion, Shoulder
- ❑ Drink alcohol
- ❑ Recreational drugs (Which? _____, How much per week? _____)
- ❑ High-pitched ringing in the ears
- ❑ Gall stones (history or current)
- ❑ Sexually transmitted disease (Which? _____)

Eyes (Liver function):

- ❑ Itchy
- ❑ Bloodshot
- ❑ Hot
- ❑ Dry
- ❑ Watery
- ❑ Gritty
- ❑ Blurry vision
- ❑ Decreased night vision
- ❑ Near-sighted
- ❑ Far-sighted

Kidney, Urinary Bladder function:

- ❑ Frequent cavities
- ❑ Easily broken bones
- ❑ Sore knees
- ❑ Weak knees
- ❑ Cold sensation in the knees
- ❑ Low back pain
- ❑ Memory problems
- ❑ Excessive hair loss
- ❑ Low-pitched ringing in the ears
- ❑ Kidney stones
- ❑ Bladder infections
- ❑ Wake during the night twice or more to urinate

❑ Lack of bladder control
❑ Fear
❑ Easily startled

Urination:
❑ Normal color
❑ Dark yellow
❑ Clear
❑ Reddish
❑ Cloudy
❑ Scanty
❑ Profuse
❑ Strong odor
❑ Burning
❑ Painful

❑ Discharge
❑ Difficult
❑ Painful
❑ Urgent
❑ Frequent

Libido:
❑ Normal
❑ High
❑ Low

Other symptoms:

Women only:

Regular menstrual cycle? ❑ Y ❑ N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
Average number of days of entire cycle:_____

Pregnant? ❑ Y ❑ N
Number of pregnancies:_____
Age of menopause (if applicable):_____

	Severe	Moderate	Slight	Normal
Vaginal discharge:	❑	❑	❑	❑
Bleeding between periods:	❑	❑	❑	❑

Do you experience any of the following pre-menstrual syndromes?

❑ nausea ❑ food cravings ❑ depression ❑ vomiting
❑ headaches ❑ irritability ❑ water retention ❑ migraines
❑ anxiety ❑ breast swelling ❑ breast tenderness
❑ other emotions:_____ ❑ dull pain, where?_____
❑ sharp pain, where?_____
❑ Other: _____

Please fill in the following menstrual chart: , even if you do not have periods.
(Put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

	Severe	Moderate	Slight	Normal
❑ Swollen testes	❑	❑	❑	❑
❑ Testicular pain	❑	❑	❑	❑
❑ Impotence	❑	❑	❑	❑
❑ Premature ejaculation	❑	❑	❑	❑
❑ Feeling of coldness or numbness in external genitalia	❑	❑	❑	❑
❑ Other_____	❑	❑	❑	❑

All please fill out:

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____