



Kwan Yin Holistic Center

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

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Person Responsible for you account _____

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

Sex: Female Male Height _____ Weight _____ Birth date _____ Age _____

Marital Status: Married Domestic Partner Single Divorced Widowed # 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:

<u>Illness</u>	<u>You</u>	<u>Your Relative</u>	<u>Approx. Date</u>	<u>Illness</u>	<u>You</u>	<u>Your Relative</u>	<u>Approx. Date</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexual Transmitted Diseases: Gonorrhea Syphilis AIDS HPV Chlamydia Herpes Date _____

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

<u>Medicine</u>	<u>Dosage</u>	<u>Reason</u>	<u>Length</u>	<u>Prescribed by</u>	<u>Date of last checkup</u>

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____
No-medical drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 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 and after menses) **Other Symptoms related to 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

Clinical Notes

(Intern's Use)

HPI:

- Onset Location Duration Characteristics
- Aggravate Related factors Treatment Significance

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 Increase libido Decreased libido Premature ejaculation Impotence
- Back pain Groin pain Testicular pain Other

Clinical Notes

(Intern's Use)

HPI:

- Onset Location Duration Characteristics
- Aggravate Related factors Treatment Significance

Clinical Notes

(Intern's Use)

HPI:

- | | | | |
|------------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> Onset | <input type="checkbox"/> Location | <input type="checkbox"/> Duration | <input type="checkbox"/> Characteristics |
| <input type="checkbox"/> Aggravate | <input type="checkbox"/> Related factors | <input type="checkbox"/> Treatment | <input type="checkbox"/> Significance |