The following is a confidential questionnaire to determine the best possible treatment plan for you. Some of the questions may seem unrelated to your condition, but they play a major role in diagnosis and treatment. Please take your time in completing this as best as you can…Thankyou!

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of children \_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance**

Medical Insurance? Yes No Relationship to insurer? Self Spouse Child Other

Name of Insured Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment and Release**: I hereby authorize my insurance benefits be paid directly to the acupuncturist and I am financially responsible for non-covered services. I also authorize the acupuncturist to release any information required to process this claim.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chief Complaint**

Chief Complaint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complaint the result of: Auto Accident Injury Job Related Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of accident, injury, other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen any other medical professional about this condition? \_\_\_\_\_\_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had this in the past? \_\_\_\_\_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_\_

What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your condition: Getting worse Constant Comes and Goes

Other complaints \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications & Supplements:** Check the box next to any of the following that you are now taking.

 Antacids  Allergy medication  Steroids

 Aspirin  Ibuprofen/Advil/Tylenol  Tranquilizers/Sleeping pills

 Cold tablets  Laxatives  Herbs

 Diet pills  Oral Contraceptives  Vitamins

 Diuretics  Blood pressure medication  Antidepressants

 Interferon  Antibiotics  Hormone replacement therapy

 Viagra  DHEA/Melatonin/ Beta HCG  Coumadin/Warfarin

Please list the names of medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medication allergies you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits:** Please mark any of the habits listed below which apply to you. Mark “**X**” for current habits.

 Mark “**✓**” for past habits.

Use of tobacco:  Yes  No If yes, # of cigarettes/day \_\_\_\_\_\_\_\_\_ age started\_\_\_\_\_\_

Use of alcohol:  Yes  No If yes, # of drinks per week \_\_\_\_\_\_\_ age started\_\_\_\_\_\_

Use of Caffeine:  Yes  No # sodas / day\_\_\_\_ # coffee / day \_\_\_\_ # tea / day\_\_\_\_

**Family Medical History:** Check “**✓**” all that apply.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | You | Relative | Date |  | You | Relative | Date |
| Cancer |  |  |  | Rheumatic Fever |  |  |  |
| Hepatitis |  |  |  | Infectious Diseases |  |  |  |
| High Blood Pressure |  |  |  | Diabetes |  |  |  |
| Stroke |  |  |  | Heart Disease |  |  |  |
| Neurological Disease |  |  |  | Seizures |  |  |  |
| Thyroid Disease |  |  |  | Emotional Disorders |  |  |  |
| Alzheimer’s |  |  |  | Tuberculosis |  |  |  |
| Gall Bladder Disease |  |  |  | Other: |  |  |  |

**Personal History:** Check “**✓**” all that apply.

General

\_\_\_\_ Anemia \_\_\_\_ Mumps \_\_\_\_ Herpes \_\_\_\_ Chronic Fatigue Syndrome

\_\_\_\_ HIV \_\_\_\_ Measles \_\_\_\_ Eating Disorders \_\_\_\_ Fibromyalgia

\_\_\_\_ Multiple Sclerosis \_\_\_\_ Chicken Pox \_\_\_\_ Jaundice \_\_\_\_ Irritable Bowel Syndrome

Cardiovascular

\_\_\_\_ High blood pressure \_\_\_\_ Dizziness \_\_\_\_ Chest pain \_\_\_\_ Cold hands/feet

\_\_\_\_ Low blood pressure \_\_\_\_ Fainting \_\_\_\_ Irregular heartbeat \_\_\_\_ Swelling in hands/feet

\_\_\_\_ Blood clots \_\_\_\_ Phlebitis \_\_\_\_ Palpitations \_\_\_\_ Other

Respiratory

\_\_\_\_ Cough \_\_\_\_ Asthma \_\_\_\_ Hay fever \_\_\_\_ Production of Phlegm

\_\_\_\_ Pneumonia \_\_\_\_ Difficulty Breathing \_\_\_\_ Tight chest What color \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Bronchitis \_\_\_\_ Difficulty breathing lying down \_\_\_\_ Coughing blood

Gastrointestinal

\_\_\_\_ Nausea \_\_\_\_ Gas \_\_\_\_ Black Stools Bowel Movements:

\_\_\_\_ Vomiting \_\_\_\_ Belching \_\_\_\_ Pain or Cramps Frequency \_\_\_\_

\_\_\_\_ Bad Breath \_\_\_\_ Rectal Bleeding \_\_\_\_ Sensitive abdomen Color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Constipation \_\_\_\_ Bloody Stools \_\_\_\_ Gastritis Odor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Diarrhea \_\_\_\_ Hemorrhoids \_\_\_\_ Peptic Ulcers Texture/form \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Heartburn \_\_\_\_ Feeling of immovable foreign object

Genito-Urinary

\_\_\_\_ Pain on urination \_\_\_\_ Frequent urination \_\_\_\_ Blood in urine \_\_\_\_ Wake up to urinate

\_\_\_\_ Incontinence \_\_\_\_ Kidney stones \_\_\_\_ Venereal disease How often \_\_\_\_\_\_\_/night

\_\_\_\_ Urgency to urinate \_\_\_\_ Impotency

Neuropsychological

\_\_\_\_ Seizures \_\_\_\_ Areas of numbness \_\_\_\_ Poor memory \_\_\_\_ Concussion

\_\_\_\_ Depression \_\_\_\_ Anxiety \_\_\_\_ Bad temper \_\_\_\_ Easily stressed

Treated for emotional problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other neurological or psychological problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin and Hair

\_\_\_\_ Rashes \_\_\_\_ Ulcerations \_\_\_\_ Hives \_\_\_\_ Itching

\_\_\_\_ Eczema \_\_\_\_ Pimples \_\_\_\_ Dandruff \_\_\_\_ Loss of hair

\_\_\_\_ Change in hair/skin texture \_\_\_\_ Purpura \_\_\_\_ Other hair or skin problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head, Eyes, Ears, Nose and Throat

\_\_\_\_ Grinding teeth \_\_\_\_ Recurrent sore throats \_\_\_\_ Facial pain \_\_\_\_ Eye Strain

\_\_\_\_ Teeth problems \_\_\_\_ Sores on lips or tongue \_\_\_\_ Poor hearing \_\_\_\_ Night blindness

\_\_\_\_ Jaw clicks \_\_\_\_ Sinus problems \_\_\_\_ Ringing in Ears \_\_\_\_ Glasses

\_\_\_\_ Dry mouth \_\_\_\_ Nose bleeds \_\_\_\_ Earaches \_\_\_\_ Eye pain

\_\_\_\_ Dry throat \_\_\_\_ Mucus \_\_\_\_ Blurry vision \_\_\_\_ Poor vision

\_\_\_\_ Copious saliva \_\_\_\_ Dizziness \_\_\_\_ Cataracts \_\_\_\_ Glaucoma

\_\_\_\_ Gum problems \_\_\_\_ Migraines \_\_\_\_ Spots in eyes \_\_\_\_ Macular Degeneration

Other head or neck problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wet or Dry type? \_\_\_\_\_\_\_\_

Sleep

\_\_\_\_ Cannot fall asleep \_\_\_\_ Excessive sleep \_\_\_\_ Lots of dreams \_\_\_\_ Wake up easily

\_\_\_\_ Wake up too early \_\_\_\_ Snoring \_\_\_\_ Tired upon waking, not refreshed

\_\_\_\_ Tossing and turning during sleep \_\_\_\_ Cannot get back to sleep after waking

Appetite

\_\_\_\_ Large \_\_\_\_ Average \_\_\_\_ None How many snacks between meals? \_\_\_\_

Temperature

\_\_\_\_ Feeling of heat, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Feeling of coldness, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Alternating chills and feverishness

Sweat

\_\_\_\_ Easily perspires \_\_\_\_ Rarely perspires \_\_\_\_ Sweating during sleep

Diet

\_\_\_\_ Prefer sweet \_\_\_\_ Prefer salty \_\_\_\_ Prefer oily food \_\_\_\_ Prefer meat

\_\_\_\_ Prefer vegetables \_\_\_\_ Prefer fruit \_\_\_\_ Prefer junk food

**Major Hospitalizations**

If you have ever been hospitalized for any serious medical illness or surgery, write in your most recent hospitalizations below. Check this box  if you have had more than three such hospitalizations. (Do not include normal pregnancies).

Last Hospitalization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Year Operation/Illness Hospital/City/State

Previous Hospitalization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Year Operation/Illness Hospital/City/State

Previous Hospitalization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Year Operation/Illness Hospital/City/State

Jamie Lee Tokubo’s office has a **24 hour cancellation policy** in order to not be charged the full price of an acupuncture visit. Of course in the case of an emergency there will be no penalty upon the patient for missing the visit. Please sign and date that you have read this policy and agree to the terms. X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPPA Compliance Requirement**

**Patient Consent to the Use / Disclosure of Patient History Information**

**for Treatment, Payment or Healthcare Operations**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that as part of my health care, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, L. Ac. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment,

A means of communication among the health professionals who contribute to my care,

A source of information for applying my diagnosis and treatment to my bill,

A means by which a third party payer can verify services billed were actually provided,

A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare

professionals.

I understand that as part of this organization’s treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax. A copy of the Notice of Information Practices is available upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

On occasion, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, L. Ac. may have confidential health information about you, such as laboratory results which we may wish to convey to you by telephone. Please indicate how you want us to handle this:

 Write only, do not call  Call this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My confidential information may be

 discussed with the following people.

**PAIN**

 Mark the areas of pain.

Describe the location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Quality of pain: (circle) dull sharp stabbing sore cramping throbbing

 burning constant radiating fixed moves about severe moderate

Rate the intensity of the pain. (circle)

(1 = A mild headache) (10 = Kidney stones or giving birth)

 1 2 3 4 5 6 7 8 9 10

Where does the pain radiates to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the onset of the pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves the pain? (circle) ice heat rest movement a.m.

 p.m. dampness dry

What aggravates it? (circle): ice heat rest movement a.m.

 p.m. dampness dry

Is there any stiffness? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any movements that aggravate the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does exercise effect your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does the pain prevent you from doing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any medications help your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other treatments have you had for the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnostic tests done:

Blood work \_\_\_ when?\_\_\_\_\_\_\_\_\_ results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X-ray \_\_\_ when?\_\_\_\_\_\_\_\_\_ results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRI \_\_\_ when?\_\_\_\_\_\_\_\_\_ results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CT scan \_\_\_ when?\_\_\_\_\_\_\_\_\_ results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMG\_\_\_ when?\_\_\_\_\_\_\_\_\_ results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any surgeries related to the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Women**

|  |  |  |  |
| --- | --- | --- | --- |
| Age of 1st period (menarche) \_\_\_\_\_\_\_\_\_\_\_ | Are you pregnant? Yes No | **Last Exam Dates and Results** | **Have you been diagnosed with:** |
| Age of last period (menopause) \_\_\_\_\_\_\_\_\_\_\_ | # of pregnancies \_\_\_\_\_\_\_\_\_ | Gynecologic exam \_\_\_\_\_\_\_\_ | Fibroids? Yes No |
|  | # of live births \_\_\_\_\_\_\_\_\_\_ | Pap smear \_\_\_\_\_\_\_\_\_\_\_\_ | Fibrocystic breasts? Yes No |
| Number of days between periods \_\_\_\_\_\_\_\_\_\_\_\_ | # of abortions \_\_\_\_\_\_\_\_\_\_ | Mammogram \_\_\_\_\_\_\_\_\_\_\_\_ | Endometriosis? Yes No |
| Number of days of flow \_\_\_\_\_\_\_\_\_\_\_\_ | # of miscarriages \_\_\_\_\_\_\_\_\_ | Bone density scan \_\_\_\_\_\_\_\_ | Ovarian cysts? Yes No |
| Color of flow \_\_\_\_\_\_\_\_\_\_ | Do you use an IUD? |  | Pelvic Inflammatory Disease? Yes No |
| Clots? Yes No |  Yes No |  | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | **Pain at Menses (Circle)** | **Location**: Lower abdomen, Lower back, Thighs, Other \_\_\_\_\_ |
| Size of clots \_\_\_\_\_\_\_\_\_\_\_ | Cramping – before, during or after | Stabbing – before, during or after | Burning – before, during or after |
| Average number of pads you use per day \_\_\_\_\_\_\_\_\_\_\_\_\_ | Dull – before, during or after | Bloating – before, during or after | Consistent – before, during or after |
|  |  | Bearing down sensation – before, during or after | Intermittent – before, during or after |
| **Discharge -** thick, thin, watery? | **Other symptoms related to menses** | Check “**✓**” all that apply: |
| Color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_Vaginal dryness | \_\_\_\_ Nausea | \_\_\_\_ Headache |
|  | \_\_\_\_ Swollen breasts | \_\_\_\_ Poor appetite | \_\_\_\_ Ravenous appetite |
| Odor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Hot flashes | \_\_\_\_ Night sweats | \_\_\_\_ Insomnia |
|  | \_\_\_\_ Vaginal itching or sores | \_\_\_\_ Decreased libido | \_\_\_\_ Increased libido |
| When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ Vaginal infections |  |  |

**Headaches**

Where do you get headaches? Mark on the images. 

How often do you get headaches? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the type of pain: (circle)

Burning Dull Consistent Stabbing Aching Intermittent

What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get headaches before, during or after your period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Men**

|  |  |  |
| --- | --- | --- |
| Date of last prostate check up \_\_\_\_\_\_\_ | **Frequency of Urination** |  |
| PSA results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Daytime \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Manual Prostate Exam results \_\_\_\_\_\_\_ | Nighttime \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Lab results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Color of Urine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Symptoms related to prostate:**  | Check “**✓**” all that apply: | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Delayed Stream | \_\_\_\_ Dribbling | \_\_\_\_ Increased Libido |
| \_\_\_\_ Incontinence | \_\_\_\_ Retention of Urine | \_\_\_\_ Decreased Libido |
| \_\_\_\_ Rectal Dysfunction | \_\_\_\_ Impotence | \_\_\_\_ Groin Pain |
| \_\_\_\_ Back Pain | \_\_\_\_ Premature Ejaculation | \_\_\_\_ Testicular Pain |

**Headaches**

Where do you get headaches? Mark on the images.



How often do you get headaches? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the type of pain: (circle)

Burning Dull Consistent Stabbing

Aching Intermittent

What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_