eliza grimes acupuncture
Acupuncture and Herbal Medicine

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

NAME:_____ DATE: _____

ADDRESS: _____

CITY:_____STATE:_____ ZIP: _____

HOME PHONE:_____ MOBILE PHONE: _____

EMAIL: _____

GENDER: _____ DATE OF BIRTH:____/_____/_____ MARITAL STATUS:_____

OCCUPATION: _____

IN EMERGENCY NOTIFY:_____PHONE:_____

PHYSICIAN:_____ PHONE: _____

ADDRESS:_____ CITY:_____STATE:_____ ZIP:_____

REFERRED BY: _____

Main Complaint (symptoms, diagnosis, duration, etc.)

_____

_____

_____

_____

_____

_____

_____

Please list any surgeries/hospitalizations (please include date of procedure)

_____

_____

_____

_____

Please list any medications you are currently taking (names & dosages)

_____

_____

_____

_____

_____

Please list all vitamins and supplements you take regularly

_____

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_____

Family Medical History

Please check any condition that applies to your immediate family.
Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

❑ Diabetes_____ ❑ Seizures_____ ❑ Heart Disease_____ ❑ Stroke_____
❑ High Blood Pressure_____ ❑ Allergies_____ ❑ Cancer_____ ❑ Asthma_____
❑ Other_____

Please give a general description of your weekly diet (breakfast, lunch, dinner, snacks)

_____

_____

_____

_____

_____

_____

Any diet restrictions? Yes No (if yes, please describe below)

_____

_____

Describe type and weekly use (# per) of:

❑ Caffeinated drinks_____ ❑ Alcohol_____ ❑ Cigarettes_____

❑ Recreational drugs _____

Do you exercise? ❑ Yes ❑ No If yes, type and frequency_____

_____

Personal History Please check any conditions or symptoms you have now.

- ❑ Arthritis
- ❑ High/Low Blood Pressure
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Thyroid Imbalance
- ❑ Lyme Disease
- ❑ Asthma
- ❑ Liver/Gall Bladder Disease
- ❑ Hypo/Hyperglycemia
- ❑ Food Allergies/Intolerance
- ❑ Raynaud's Disease
- ❑ Respiratory
- ❑ Chronic Pain Condition
- ❑ Infertility
- ❑ Stroke
- ❑ Kidney Disease
- ❑ Diverticulitis/IBS
- ❑ Chronic Fatigue
- ❑ Allergies
- ❑ Impotence
- ❑ Emphysema
- ❑ Heart Disease
- ❑ Cancer
- ❑ Ulcer Seizures
- ❑ Anemia
- ❑ Alcoholism
- ❑ Gastritis/Pancreatitis
- ❑ Elevated Blood Cholesterol

Please check any sign/symptom that is a current issue or has occurred within the past year.

General

- ❑ Poor Appetite
- ❑ Eating Disorder
- ❑ Night sweats
- ❑ Cravings
- ❑ Weight loss/gain
- ❑ Poor sleeping
- ❑ Chills
- ❑ Sweats easily
- ❑ Localized weakness
- ❑ Peculiar tastes/smells
- ❑ Fatigue
- ❑ Tremors
- ❑ Poor balance
- ❑ Muscle weakness/fatigue
- ❑ Fevers
- ❑ Strong thirst (hot or cold drinks)
- ❑ Bleed/Bruise easily
- ❑ Sudden energy drop

Skin and Hair

- ❑ Rashes
- ❑ Eczema/Psoriasis
- ❑ Skin discoloration
- ❑ Warts
- ❑ Ulcerations
- ❑ Dandruff
- ❑ Acne
- ❑ Fungal Infection
- ❑ Hives/Allergic Dermatitis
- ❑ Loss of hair
- ❑ Change in skin/hair texture
- ❑ Weak or ridged nails
- ❑ Itching
- ❑ Recent moles
- ❑ Dermatitis

Head, Eyes, Ears, Nose and Throat

- ❑ Dizziness
- ❑ Eye pain
- ❑ Ringing in ears
- ❑ Nose bleeds
- ❑ Sores on lips/tongue
- ❑ Difficulty swallowing
- ❑ Poor vision
- ❑ Poor hearing
- ❑ Recurrent sore throats/colds
- ❑ Dental problems
- ❑ Migraines
- ❑ Blurred vision
- ❑ Spots in front of eyes
- ❑ Grinding teeth
- ❑ Jaw clicks/locks
- ❑ Glasses
- ❑ Earaches
- ❑ Sinus problems
- ❑ Facial pain
- ❑ Headaches

Cardiovascular

- ❑ Chest pain or pressure
- ❑ Cold hands/feet
- ❑ Shortness of breath
- ❑ Low blood pressure
- ❑ Irregular heart beat
- ❑ Swelling of hands/feet
- ❑ Varicose/spider veins
- ❑ Spontaneous sweating
- ❑ Palpitations at rest
- ❑ Blood clots
- ❑ Pressure in chest
- ❑ Dizziness
- ❑ Fainting
- ❑ Phlebitis
- ❑ High blood pressure

Respiratory

- ❑ Cough/Wheezing
- ❑ Pneumonia
- ❑ Difficulty breathing when lying down
- ❑ Coughing blood
- ❑ Pain with deep inhalation
- ❑ Asthma
- ❑ Tight sensation in chest
- ❑ Production of phlegm - what color?_____
- ❑ Bronchitis
- ❑ Difficult inhale/exhale

Gastrointestinal

- ❑ Nausea
- ❑ Gas
- ❑ Indigestion
- ❑ Bloating/Edema
- ❑ Hernia
- ❑ Vomiting
- ❑ Belching
- ❑ Bad breath
- ❑ Abdominal pain/cramps
- ❑ Significant thirst
- ❑ Diarrhea
- ❑ Black stools
- ❑ Rectal pain
- ❑ Changes in appetite
- ❑ IBS/Crohn's Disease
- ❑ Constipation
- ❑ Blood in stool
- ❑ Hemorrhoids
- ❑ Acid reflux/GERD

Genito-Urinary

- ❑ Pain on urination
- ❑ Unable to hold urine
- ❑ Burning urination
- ❑ Frequent urination
- ❑ Scanty flow
- ❑ Dribbling after urination
- ❑ Blood in urine
- ❑ Copious flow
- ❑ Night Urination Infections
- ❑ Urgent urination
- ❑ Urinary tract infection

Musculoskeletal

- ❑ Neck pain
- ❑ Knee pain
- ❑ Muscle pain
- ❑ Rotator Cuff
- ❑ Shoulder pain
- ❑ Sprains/Strains
- ❑ Muscle weakness
- ❑ Back pain Low___ Middle___ Upper___
- ❑ Hand/wrist pain
- ❑ Sciatica
- ❑ Tendonitis
- ❑ Carpal Tunnel
- ❑ Foot/ankle pain Hip pain
- ❑ Bursitis

Neuropsychological

- ❑ Seizures
- ❑ Lack of coordination
- ❑ Anxiety/Panic attacks
- ❑ Nervousness
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Bad temper/irritable
- ❑ ADD/ADHD
- ❑ Vertigo/Dizziness
- ❑ Concussion
- ❑ Easily susceptible to stress
- ❑ Manic Depression
- ❑ Areas of numbness
- ❑ Depression
- ❑ Seasonal Affective Disorder

Male

❑ Genital pain
❑ Impotence
❑ Low sexual energy
❑ Penis discharge
❑ Genital sores
❑ Lumps in testicles

Female

❑ Difficult/Painful intercourse
❑ Vaginal dryness
❑ Vaginal sores
❑ Vaginal discharge
❑ Infertility
❑ Irregular menstruation
❑ Low sexual energy
❑ Ovarian cysts
❑ Endometriosis
❑ Uterine Fibroids
❑ Fibrocystic breast tissue
❑ Polycystic Ovarian Disease
❑ Painful menstruation
❑ Age of first menses_____
❑ Date of last menses_____
❑ Date of last PAP/Pelvic_____
❑ Number of pregnancies____
❑ Number of ectopic pregnancies_____
❑ Number of live births_____
❑ Number of miscarriages_____

Irregular PAP? ❑ Yes ❑ No If yes, date(s) and treatment_____
Is your period regular? ❑ Yes ❑ No How long is your cycle?_____
How many days of flow?_____
Please describe any PMS signs/symptoms_____
_____

Do you practice birth control? ❑ Yes ❑ No
If yes, what type? _____
For how long?_____

Please feel free to list/ describe any other issues you would like to discuss

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