Patient Information

Happy Laughter: Acupuncture & Chinese Medicine
Lilydale | Yarra Junction
0411 146 067

Patient Name: Dr / Mr / Mrs / Ms / Miss _____

Date of Birth: _____ **Age:** _____ **Male:** _____ **Female:** _____

Single: _____ **Married:** _____ **Separated:** _____ **Divorced:** _____ **Widowed:** _____

Street Address: _____

Suburb_____ **State:** _____ **Post Code:** _____

Postal Address (If different than above**)**_____

Home Phone: _____ **Mobile Phone:**_____

Email (for emailing receipts):_____

Occupation: _____ **Employer:** _____

Emergency Contact:

Name: _____**Relationship**_____ **Phone #:** _____

Medicare Card Number:_____**Reference no:**_____

Pension/Concession Card no:_____**Expiry:**_____

How did you hear about us?: _____

Date: _____

Patient Signature: _____

Health History Questionnaire

Major Complaint(s):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

How do these conditions affect your daily activities?: _____

_____

Primary Physician: _____

Other physicians/therapists: _____

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

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

_____

Health History Questionnaire

List all hospital stays, surgeries, or major illnesses that you have had since birth	Year Occurred

Test	Year	Test Results
☐ Physical	_____	_____
☐ Cholesterol	_____	_____
☐ Prostate	_____	_____
☐ Mammogram	_____	_____
☐ Pap Smear	_____	_____
☐ Blood	_____	_____
☐ HIV/STD	_____	_____

Please check if you have or had any of the following conditions

☐ Diabetes	☐ Syphilis	☐ Mumps	☐ Jaundice
☐ Heart Disease	☐ CVA (Stroke)	☐ Rheumatic Fever	☐ Hepatitis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Vein Condition
☐ Allergies	☐ Gonorrhea	☐ Bleeding Tendency	☐ Tuberculosis
☐ Meningitis	☐ Measles	☐ High Blood Pressure	☐ Chicken Pox
☐ Epilepsy	☐ HIV	☐ Nervous Disorder	☐ Polio
☐ Paralysis	☐ High Fever	☐ Glandular Fever	☐ Migraines
☐ Glaucoma	☐ Cancer	☐ Multiple Sclerosis	☐ Anxiety

Health History Questionnaire

Please check all the symptoms that you are currently experiencing or have experienced in the LAST 6 MONTHS.

What makes the pain better?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other: _____

What makes the pain worse?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Describe Your General Pain

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Lung & Kidney Function (Overall Temperature)

- ☐ Shortness of breath
- ☐ General weakness
- ☐ Daily chronic fatigue & malaise
- ☐ Low energy
- ☐ Difficulty keeping eyes open (daytime)
- ☐ Easily catch colds
- ☐ Feel worse after exercise

TOTAL BOXES CHECKED: _____

Liver, Spleen, Heart Function

- ☐ Dizziness
- ☐ See floating black spots

TOTAL BOXES CHECKED: _____

Heart Function

- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Trouble falling and/or staying asleep

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Pancreas/Spleen Function

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Worry
- ☐ Gurgling noise in stomach
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Prolapsed organs: _____
- ☐ Overthinking

TOTAL BOXES CHECKED: _____

Small/Large Intestine Function

- ☐ Loose stools
- ☐ Constipated
- ☐ Incomplete stools
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

TOTAL BOXES CHECKED: _____

Lung Function

- ☐ Nasal discharge (color: _____)
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Allergies (type: _____)
- ☐ Alternation of chills/fever
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Sneezing
- ☐ Headache (location: _____)
- ☐ Overall achy feeling in body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (per day: _____)
- ☐ Sadness
- ☐ Melancholy

TOTAL BOXES CHECKED: _____

Stomach Function

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad Breath
- ☐ Canker sores (mouth ulcers)
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach pain
- ☐ Vomiting

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Dampness Trapped in the Body

- ☐ Bodily sensation of heaviness
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

TOTAL BOXES CHECKED: _____

Liver Function (Eyes)

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

TOTAL BOXES CHECKED: _____

Liver, Gall Bladder Function

- ☐ Alternating diarrhea & constipation
- ☐ Chest pain
- ☐ Tight sensation in chest
- ☐ Bitter taste in mouth
- ☐ Anger easily
- ☐ Depression
- ☐ Frustration
- ☐ Irritability
- ☐ Skin rashes
- ☐ Headache at the top of the head
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Muscle spasms
- ☐ Seizures
- ☐ Convulsions
- ☐ Lump in the throat
- ☐ Neck tension
- ☐ Shoulder tension
- ☐ Limited range of motion in neck
- ☐ Limited range of motion in shoulder
- ☐ Alcohol consumption (per day: _____)
- ☐ Recreational drug use (which: _____)
- ☐ High-pitched ringing in ears
- ☐ Gallstones
- ☐ STD's (which: _____)
- ☐ Unable to adapt to stress

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Kidney Function (Overall Temperature)

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temp. sensation
- ☐ Cold body temp. sensation
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet & chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Do you take water to bed

TOTAL BOXES CHECKED: _____

Kidney (Urinary Bladder Function)

- ☐ Frequent cavities, teeth problems
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Lack of bladder control
- ☐ Wake during the night to urinate
- ☐ Fear
- ☐ Easily Startled

TOTAL BOXES CHECKED: _____

Urination (Bladder Function)

- ☐ Color: Pale ___ Dark Yellow ___ Clear ___
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning sensation
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

TOTAL BOXES CHECKED: _____

Libido

- ☐ Low
- ☐ Normal
- ☐ High

Health History Questionnaire

WOMEN ONLY

Do you have a regular menstrual cycle?:	☐ **Yes**	☐ **No**
Are you pregnant?:	☐ **Yes**	☐ **No**
Do you have bleeding between periods?	☐ **Yes**	☐ **No**
Do you have a vaginal discharge?	☐ **Yes**	☐ **No**

Menstrual Cycle Symptoms

- ☐ **Nausea**
- ☐ **Vomiting**
- ☐ **Food cravings**
- ☐ **Water retention**
- ☐ **Breast swelling**
- ☐ **Breast tenderness**
- ☐ **Headaches**
- ☐ **Migraines**
- ☐ **Dull pain**
- ☐ **Sharp pain**
- ☐ **Depression**
- ☐ **Irritability**
- ☐ **Anxiety**
- ☐ **Other:** _____

TOTAL BOXES CHECKED: _____

MEN ONLY

- ☐ **Swollen testes**
- ☐ **Testicular pain**
- ☐ **Impotence**
- ☐ **Premature ejaculation**
- ☐ **Coldness or numbness external genitalia**
- ☐ **Other:** _____

TOTAL BOXES CHECKED: _____

Wellness Assessment

Please take you time with each of the following questions. Our method of obtaining optimal results beings here. In order for us to offer you the best care it is essential that we ascertain your current state of overall health. As we go through this paperwork with you, we encourage any questions or thoughts you may have.

Name:_____ **Date:**_____

Chief Complaints:

1. _____ **How Long?**_____
2. _____ **How Long?**_____
3. _____ **How Long?**_____
4. _____ **How Long?**_____

What have you tried doing to resolve this problem? Did it work?

_____

_____

Have you become discouraged about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work:_____

Family:_____

Hobbies:_____

Life:_____

Do you know how this problem may have started?_____

_____

Are there any health conditions you are afraid these problems might turn into? Please check all that apply.

- ☐ Diminish future abilities
- ☐ Stress
- ☐ Weight gain
- ☐ Heart disease
- ☐ Depression
- ☐ Surgery
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

What aspect of your life would be better without these problems? Please check all that apply.

- ☐ Less stress
- ☐ More Energy
- ☐ Self esteem
- ☐ Confidence
- ☐ Work
- ☐ Outlook on life
- ☐ Family
- ☐ Sleep

On a typical day, what do you eat and drink for:

Breakfast:_____

Lunch:_____

Dinner: _____

Snacks:_____

Do you have any emotional eating habits? If so, what are they? _____

_____

How have you taken care of your health in the past? Please check all that apply.

- ☐ Medication
- ☐ Acupuncture
- ☐ Exercise
- ☐ Chiropractic
- ☐ Other: _____
- ☐ Routine Medical
- ☐ Physiotherapy
- ☐ Diet and Nutrition
- ☐ Vitamins

How did the previous methods work for you?_____

_____

Would you like improvement with any of the following?

- ☐ Digestion: bloating, acid reflux, gas, constipation, diarrhea
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of well being
- ☐ Energy levels and focus
- ☐ Emotional Balance

Are you here visiting us to (please check all that apply):

☐ **Resolve any immediate problem**
☐ **Health rehabilitation to restore proper functions**
☐ **Other: _____**

If you were to sit down and discuss your life 3 years from now and look back at today, what changes would you like to experience for you to be happy with your progress?

(Please take your time and include anything that is part of your happiness, include health, family, work, finances, travel, marriage, or personal goals).

_____
_____
_____
_____
_____
_____

What potential barriers do you foresee that would prevent these things from happening?

_____
_____
_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____
_____
_____

How important is it for you to resolve your health concerns?

(Rate on a scale of 1 to 10. 10 being extremely important) _____

We see excellent results because we take the time to evaluate your health conditions and personal goals. If we feel like our program can help you accomplish those goals, we will create an action plan for you at the time of your visit.

- **Please bring any lab work pertinent medical information you have within the past 6 months**