BLUE PHOENIX WELLNESS

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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 _____

Email _____

Occupation _____ Person Responsible for your 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

Have you received acupuncture therapy before? ☐ Yes ☐ No

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date		You	Your Relative	Approx. Date
Cancer	☐	☐	_____	Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____	High Blood Pressure	☐	☐	_____
Hepatitis B/C	☐	☐	_____	Psychiatric Disorders	☐	☐	_____

Sexual Transmitted Diseases: ☐ Gonorrhoea ☐ Syphilis ☐ AIDS ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Date _____

Please indicate if any of the following pertain to you:

☐ Low Blood Pressure ☐ Pregnancy ☐ Strep Infection
☐ Faint ☐ Latex Allergy ☐ Lymph nodes removed
☐ Seizures ☐ Lyme disease ☐ Alcoholism
☐ Pacemaker ☐ Asthma ☐ Birth Trauma
☐ Blood -Thinning Meds ☐ MS

☐ Other Allergies: To What?_____

Other Major Illnesses, Injuries, Surgeries, Cosmetic Work:

Please provide details: _____

When? (Dates) _____

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	Length	Prescribed by	Date of last checkup

DIET

Breakfast	Lunch	Diner	Snacks

Food cravings: _____

Food intolerance: _____

How much do you consume (servings per day/week)

Meat _____ Sugar/Sweets _____ Dairy/Cheese/Milk _____

Are you always thirsty? ☐ Yes ☐ No Do you prefer ☐ Hot or ☐ Cold drinks?

Taste Preference: ☐ Salty ☐ Sour ☐ Bitter ☐ Sweet ☐ Spicy

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	☐	☐		Tobacco	☐	☐		Water Intake	☐	☐	
No-medical drugs	☐	☐		Alcohol	☐	☐		Soda pop	☐	☐	

SYMPTOM SURVEY (FOR EVERYONE)

General

___Recurrent Infections
___ Night Sweats
___Sweat easily
___ Bleed or bruise easily
___Thirst with no desire to drink
___Fatigue
___Sudden energy drops
Time of day_____
___Poor Sleep
___Tremors
___Poor Balance
___Edema

Skin

___ Rashes
___Itching
___Eczema
___Oozing
___Pimples
___Dry skin / scalp
___Recent moles

Cardiovascular

___Chest discomfort/pain
___Heart Palpitations
___Cold hands or feet
___Swelling of hands or feet
___Blood Clots
___Spider veins
___Fainting
Other _____

Respiratory

___Difficulty breathing
___Pain with breathing
___Shallow breathing
___Shortness of breath
___Production of phlegm
color _____
___Recurrent cough
___Bronchitis
___Pneumonia
___Asthma/Wheezing
Other _____

Digestion

___Bad breath
___Change in appetite
___Nausea
___Vomiting
___Heartburn
___Indigestion
___Belching
___Abdominal pain or cramps
___Weight gain
___Weight loss
___Loose stools / Diarrhea
___Strong smelling stools
___Bloody stools
___Pale stools
___Green stools
___Black stools
___Constipation
(not daily, or difficult)
___Pain with passing stools
___Gas
___Rectal pain
___Hemorrhoids
___Anorexia nervosa
___Bulimia
Other _____

Head/Eyes/Ears/Nose/Throat

___Headache
Where _____
When _____
___Migraines
___Dizziness
___Discharge from ear
___Poor hearing
___Ringing in ears
___Blurry vision
___Night blindness
___Color blindness
___Spots in front of eyes
___Eye pain
___Excessive tearing
___Glasses
___Sore eyes
___Facial pain
___Nose bleeds
___Nasal discharge
___Blocked nose
___Snoring
___Grinding teeth
___Teeth problems
___Recurrent sore throat
___Hoarseness
___Tonsillitis
___Swollen glands
___Sores on lips/mouth
Other _____

Genito-Urinary

___Pain on urination
___Urgency with urination
___Frequent urination
___Blood in urine
___Decrease in urinary flow
___Unable to hold urine
___Incontinence at night
___Dribbling urination
___Kidney stones
___Prostate problems
___Impotency
___Changes in sexual drive
___Rashes
___Do you wake at night to urinate?
How many times? _____
Other _____

Musculoskeletal

___Neck ache/pain
___Back ache/pain
___Knee ache/pain
___Shoulder pain
___Elbow/Forearm pain
___Hand/Wrist pain
___Foot/Ankle pain
___Joint/Bone problems
___Torn tissues
___Prostheses
___Muscle pain/weakness
___Hernia
Other _____

Neurological

___Seizures
___Nerve damage
___Paralysis
___Stroke
___Sleep disorder
___Concussion
___Vertigo
___Lack of coordination
___Loss of balance
___Poor memory
___Difficulty in concentrating
Other _____

Behavioural

___Vacant
___Moody
___Easily susceptible to stress
___Aggressive/Bad temper
___Lose control of emotions
___Anxiety
___Panic Attacks
___Depression
___Fear

What are the main health problems for which you are seeking treatment? _____
_____
What other forms of treatment have you sought? _____
_____

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing:

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Diet	☐	☐	☐	☐	☐	
Self	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	

FOR WOMEN

of pregnancies____ # births ____ # premature births ____ # miscarriages ____ # abortions ____
Age of 1st menses____ # days between menses ____ Duration of menses ____
Age of menopause ____

___Painful periods ___Irregular periods ___Light periods ___Heavy periods

Other symptoms related to menses:
___Discharge ___Headache ___Nausea ___Constipation ___Diarrhea
___Swollen Breasts ___Mood Swings ___Increased Appetite ___Decreased Appetite ___Insomnia

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 _____

FOR PAIN PATIENTS

Please note the severity of your problem right now:

No Problem Worst Imaginable

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

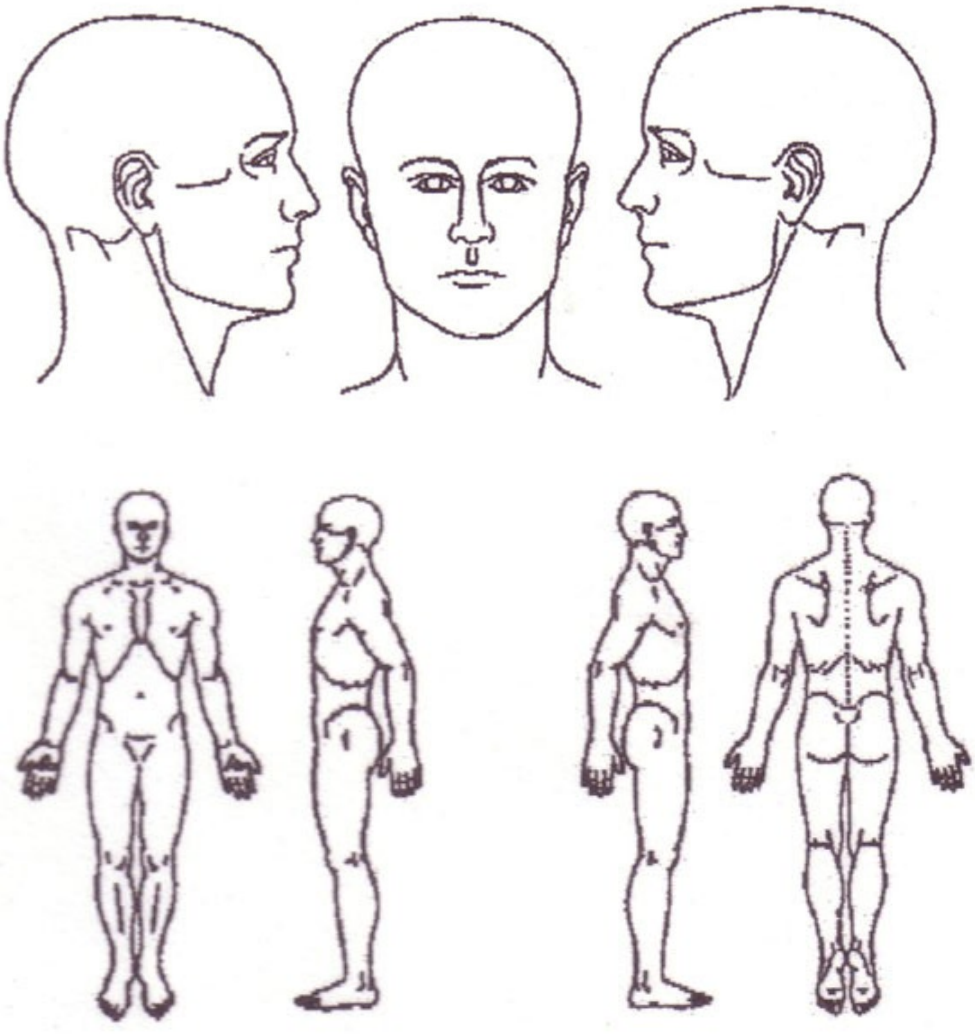
Please note the greatest degree of severity of your problem within the last week:

No Problem Worst Imaginable

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Please note the greatest degree___above___ Click on image and put "X" where you have pain

To utilize our diagram tool, use your Return key to move the cursor downward and the Spacebar to move it from left to right, and mark the spot with an X.
(You can use the arrow keys for greater ease once you've started the process.)



Comments:

PLEASE COMPLETE ALL PAGES AND CLICK HERE Submit