Dana Schwartz L.Ac.

Ancient wisdom, with a modern mindset

This is a confidential questionnaire to help determine the best treatment plan for you. Please take the time to fill it out as completely and accurately as possible. If you have any questions, please feel free to ask. Thank you.

Personal Information

Name_____

Home Address: _____

City_____State_____Zip_____

Phone_____ Cell_____ E-mail_____

Birthdate_____ Age _____ Marriage Status (circle one): M S W D

Occupation _____ Employer _____

Your Hometown _____ Who referred you?_____

If under 18, person responsible for your account_____

Emergency Contact: Name:_____

Phone:_____ Relationship to you? _____

Have you had acupuncture therapy before? □ Yes □ No

Chief Complaint

What is the health concern for which you are seeking treatment?
(physical, mental, emotional, or spiritual)

_____

_____

_____

How long have you had this condition?

_____

What other forms of treatment have you sought?

_____

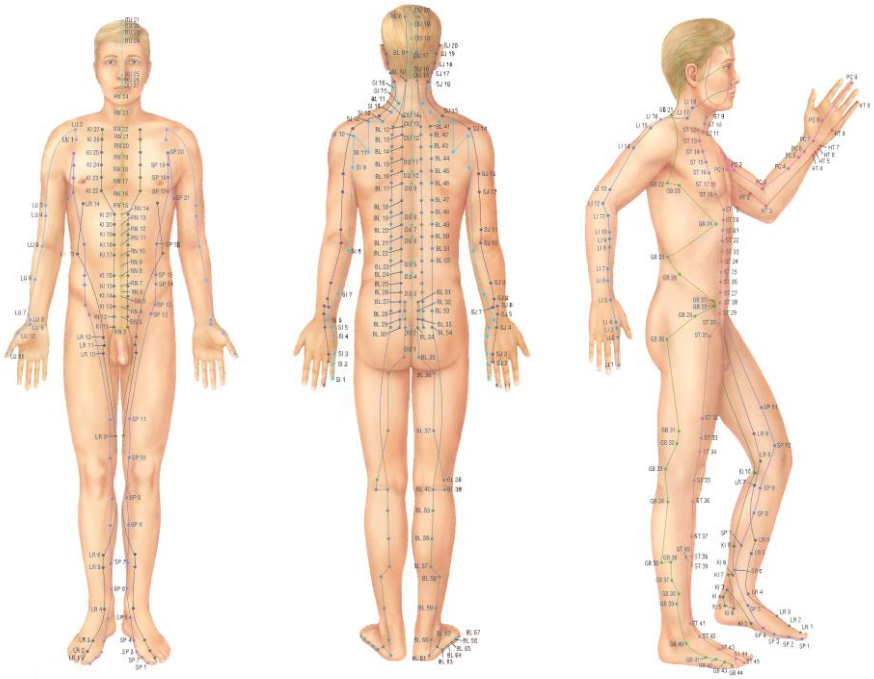
What helps your condition?

_____

What makes your condition worse?

_____

Please indicate areas of concern as well as areas with scars:



How would you characterize your condition?: □ Dull/Achy □ Sharp/Stabbing
□ Burning □ Tingling □ Numbness □ Electrical □ Other: _____

What would you like to achieve with acupuncture treatment? _____

_____

_____

Please check which services besides acupuncture you would be interested in:

□ Chinese herbal medicine □ Therapeutic massage □ Cleansing □ Qi gong health exercises
□ Meditation techniques □ Nutritional consultation □ Shamanic Offerings

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, though it may restrict some of our treatment modalities):

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

Symptom Survey

Please CHECK the symptoms or conditions you experience:

HT

□ Fidgetiness
□ High Blood Pressure
□ Chest Pain
□ Cold Hands & Feet
□ Low Blood Pressure
□ Night Sweating
□ Swelling of Hands & Feet
□ Dizziness
□ Insomnia
□ Palpitations
□ Irregular Heartbeat
□ Nightmares
□ Poor memory
□ Awakens Easily
□ Oversleep
□ Laughing for No Reason
□ Depression or Anxiety
□ Sweats Easily
□ Claustrophobia
□ Restless sleep
□ Bitter Taste in AM
□ Sores on Tongue Tip

LU

□ Chills
□ Fever
□ Cough
□ Coughing Blood
□ Asthma
□ Pneumonia
□ Short of Breath
□ Bronchitis
□ Sinus Problems
□ Phlegm
□ Common Cold
□ Sore Throat
□ Pain w/Deep Breath
□ Nosebleeds
□ Loss of Voice
□ Sadness or Grief
□ Skin Problems
□ Nasal Problems
□ Gets Sick Easily
□ Decreased Sense of Smell
□ Spontaneous Sweat for No Reason

SP/ST

□ Stomach Pain
□ Gas and Bloating
□ Acid Reflux/GERD
□ Nausea/Vomiting
□ Belching/Burping
□ Indigestion
□ Foul Breath
□ Hemorrhoids
□ Varicose Veins
□ Bruises Easily
□ Fatigue
□ Intestinal Pain or Cramps
□ Diarrhea
□ Loose Stool
□ Constipation
□ Thirst
□ Excess Appetite
□ No Appetite
□ Obsession in Work or Relationships
□ Use of Antibiotics
□ Soft Nails
□ Colitis/Diverticulitis
□ Blood In Stool
□ Mouth Sores
□ Weight Gain/Loss

LR

□ Easily Angered
□ Headaches
□ Migraines
□ Eye Problems
□ Jaundice
□ Gallstones
□ Light Colored Stools
□ Brittle Nails
□ High Cholesterol
□ Facial Redness
□ Dizziness
□ Numbness
□ Muscle Spasms
□ Pain in Ribs
□ Sighs Often
□ Bitter Taste During the Day
□ Difficulty Digesting Oily Foods

KD

□ Erectile Dysfunction
□ Spermatorrhea
□ Low Back Pain
□ Knee Problems
□ Hearing Impairment
□ Ear Ringing
□ Kidney Stones
□ Hair Loss
□ Decreased Sex Drive
□ Impotence
□ Prostate Problems
□ Panic Attacks/Fear
□ Weak Bones/Joints
□ Dental Problems
□ Edema/ Swelling
□ Night Urination
□ Urinary Problems
□ Feel Cold
□ Night Sweating
□ Prematurely Gray Hair
□ Discharge

Do you usually feel hot/warm or cold/chilled? _____
Do you desire hot or cold liquids? _____
Are you predominantly □ Right Handed □ Left Handed
Do you have any surgical implants? □ Yes □ No

Health History

DIET: Please list the foods you eat on a typical day:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Please indicate the frequency with which you ingest any of the following:
Coffee _____ Soda/Pop_____
Water _____Alcohol_____
Recreational drugs _____ Tobacco_____

Please list any ALLERGIES you may have _____

Please list any prescription or over-the-counter MEDICATIONS you take:

Medication/Supplement Amount Reason
_____
_____
_____
_____
_____
_____

Please list any major health incidents (SURGERIES, ACCIDENTS, TRAUMAS, etc.) in your life and the date they occurred:
_____

_____

Do you EXERCISE? If so, what type and how often?_____

Describe your SLEEP:
□ I have difficulty falling asleep □ I wake a lot during the night □ I dream alot □ I have night sweats and/or palpitations □ I frequently go to sleep with a full belly □ I wake too early □ I am easily awakened and can't go back to sleep
□ I wake feeling refreshed

What is your ENERGY LEVEL on a scale of 1 to 10 (10=energizer bunny)? _____

Do you have or has anyone in your family had a HISTORY of any of the following:

□ Cancer	□ Asthma	□ Seizures
□ Diabetes	□ Hepatitis	□ Allergies
□ Heart Disease	□ High Blood Pressure	□ Alcoholism
□ Drug Dependency	□ Stroke	□ Thyroid Disease/Goiter
□ Mental Illness	□ Bulimia or Anorexia	□ Suicide/Attempts

□ Other _____

♀For Women

Age of first period: _____ Fist Date of Last Period: _____

Number of children (names and ages):_____
_____

Number of miscarriages: _____ Number of abortions:_____

Number of days between periods (your cycle): _____

Color of flow: □ Light Red □ Red □ Dark Red □ Purple □ Brown □ Black

Is there clotting? □ Yes □ No **Number of days of flow:**_____

Please indicate the amount of flow per day: (ex. Heavy for 1st two days; Medium for 2nd and 3rd day; Light for last day)
□ Heavy (change pad/tampon every 1-3 hours) for
□ Medium (change pad every 3-4 hours) for
□ Light (change pad every 4-6 hours or less) for

What form of birth control do you use? _____

Have you ever been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis
□ Ovarian Cysts □ PID □ Polycystic Ovary Syndrome
□ STD _____

Please CHECK any other menstrual symptoms you experience:

Kidney Yin □ Hot Flashes □ Vaginal Dryness □ Mid-cycle Cervical Mucus Scanty or Missing □ Dark Circles Under Eyes □ Night Sweats
Kidney Yang □ Pre-Menstrual Low Back Pain □ Low Libido □ Profuse Vaginal Discharge □ Cold Cramps During Period that Respond to a Heating Pad
Spleen □ Anemia □ Thin, profuse or pinkish menstruation □ Spotting Before Period □ Especially Tired Around Ovulation or Menstruation □ Polyps □ Ever Been Diagnosed with Uterine Prolapse □ Hypothyroid □ Menstrual Cramps With a Bearing Down Sensation in Uterus
Blood Deficiency □ Scant or Late Menses □ Dry, Flaky Skin □ Chapped lips □ Fingernails or Toenails Brittle □ Hair Brittle or Dry □ History of Vegetarianism □ Diminished Nighttime Vision □ Light-headed or Dizzy Around Period □ Lips, tongue, or Inner Lower Eyelids Pale in Color

Blood Stasis

□ Brown or Black Menstrual Blood
□ Painful, Unmovable Breast Lumps
□ Cherry red Spots (Hemangiomas) on Skin?
□ Piercing or Stabbing Menstrual Cramps
□ History of Vascular Abnormality or Clotting Disorder
□ Mid-Cycle Pain Around Ovaries
□ Varicose or Spider Veins
□ Chronic Hemorrhoids
□ Clotty Menstrual Blood
□ Dark Spots in Your Eyes

Liver Stagnation

□ Pre-Menstrual Irritability
□ Breast Sensitivity at Ovulation
□ Pre-Menstrual Breast Distention or Pain
□ Bloated or Irritable Around Ovulation
□ Nipple Pain or Discharge
□ Painful Menses
□ Menstrual Cramp Pain in External Genital Area
□ Thick, Dark or Purplish Menstrual Blood

Excess Heat

□ Hot Flashes
□ Short Menstrual Cycle
□ Red Acne, Especially Pre-Menstrually
□ Vaginal Irritation

Dampness

□ Fibrocytic Breasts
□ Yeast Infections Often
□ Cystic or Pustular Acne
□ Vaginal Itching
□ Overweight
□ Body is like a barometer; you can tell when it will rain
□ Menstrual Blood with Stringy Tissue or Mucus

Thank you for your time in filling this form out as completely as possible. If you feel there are any important pieces of your health history or personal experience that was not asked, please take your time to write them here.

Blessings!