

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Previous or referring doctor:		Date of last physical exam:	
Reason for Visit:		How did you hear about us? <i>(We would like to thank the person that referred you.)</i>	

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
Do you have a pacemaker?	<input type="checkbox"/> Y <input type="checkbox"/> N	

List any medical problems that other doctors have diagnosed

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Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies (medications, foods, seasonal)	
Name the Drug, Food etc.	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	# of meals you eat in an average day?				
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day		<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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:
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<input type="checkbox"/> Vomiting	<input type="checkbox"/> Belching	<input type="checkbox"/> Pain or Cramps	Frequency <input type="checkbox"/>
<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Sensitive abdomen	Color <input type="checkbox"/>
<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Gastritis	Odor <input type="checkbox"/>
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Peptic Ulcers	Texture/form <input type="checkbox"/>
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Feeling of immovable foreign object		

Genito-Urinary

<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Wake up to urinate
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Venereal disease	How often <input type="checkbox"/> /night
<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Impotency		

Neuropsychological

<input type="checkbox"/> Seizures	<input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Concussion
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Bad temper	<input type="checkbox"/> Easily stressed
Treated for emotional problems? <input type="checkbox"/>		Other neurological or psychological problems? <input type="checkbox"/>	

Skin and Hair

<input type="checkbox"/> Rashes	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching
<input type="checkbox"/> Eczema	<input type="checkbox"/> Pimples	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Change in hair/skin texture	<input type="checkbox"/> Purpura	<input type="checkbox"/> Other hair or skin problems	<input type="checkbox"/>

Head, Eyes, Ears, Nose and Throat

<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Recurrent sore throats	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Eye Strain
<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Sores on lips or tongue	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Night blindness
<input type="checkbox"/> Jaw clicks	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Glasses
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Earaches	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Dry throat	<input type="checkbox"/> Mucus	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Poor vision
<input type="checkbox"/> Copious saliva	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gum problems	<input type="checkbox"/> Migraines	<input type="checkbox"/> Spots in eyes	<input type="checkbox"/> Macular Degeneration
Other head or neck problems <input type="checkbox"/>			Wet or Dry type? <input type="checkbox"/>

Sleep

<input type="checkbox"/> Cannot fall asleep	<input type="checkbox"/> Excessive sleep	<input type="checkbox"/> Lots of dreams	<input type="checkbox"/> Wake up easily
<input type="checkbox"/> Wake up too early	<input type="checkbox"/> Snoring	<input type="checkbox"/> Tired upon waking, not refreshed	
<input type="checkbox"/> Tossing and turning during sleep	<input type="checkbox"/> Cannot get back to sleep after waking		

Appetite

<input type="checkbox"/> Large	<input type="checkbox"/> Average	<input type="checkbox"/> None	How many snacks between meals? <input type="checkbox"/>
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Temperature

<input type="checkbox"/> Feeling of heat, where? <input type="checkbox"/>	
<input type="checkbox"/> Feeling of coldness, where? <input type="checkbox"/>	<input type="checkbox"/> Alternating chills and feverishness

Sweat

<input type="checkbox"/> Easily perspires	<input type="checkbox"/> Rarely perspires	<input type="checkbox"/> Sweating during sleep
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Diet

<input type="checkbox"/> Prefer sweet	<input type="checkbox"/> Prefer salty	<input type="checkbox"/> Prefer oily food	<input type="checkbox"/> Prefer meat
<input type="checkbox"/> Prefer vegetables	<input type="checkbox"/> Prefer fruit	<input type="checkbox"/> Prefer junk food	

CONSENT FOR TREATMENT

NAME _____ Phone (H) _____ (W) _____

Street _____ City _____ State _____ Zip _____

BIRTHDATE _____ Email _____

SEX _____ AGE _____ Height _____ Weight _____

Personal Physician _____ Date of last physical _____

EMERGENCY CONTACT _____ Phone _____

ALLERGIES _____

MEDS/SUPPLEMENTS _____

I, the undersigned, an adult over the age of 18, hereby consent to receive acupuncture treatment from Craig Fiorini, L.Ac., Dipl. OM

I am fully aware that the acupuncture needles are sterile and disposable and that no needle used on my person has ever been used on another person.

I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, bruising, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms.

I understand that acupuncture and Chinese medicine is not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of or concurrently with acupuncture treatment.

I fully realize that I may withdraw from my treatment at any time.

I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

Craig graduated with his Master of Science in Oriental Medicine, Southwest Acupuncture College May 2009. The degree program includes 3045 hours of training in Acupuncture and Chinese Herbs but it also includes over 600 hours in Bioscience as well as over 1140 hours of clinical experience. Craig is a Diplomate of Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine and holds a current license in the state of Colorado. Craig Fiorini has training and experience in the recommendation and application of such adjunctive therapies as Chinese Herbal Medicine, Moxabustion, Cupping, Tuina, and Gua Sha. These therapies are recommended and applied based on Traditional Chinese medical concepts.

Craig's clinical practice complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized. He received his Colorado acupuncture license in 2009. Craig has never had a certificate, license or registration revoked or suspended in Colorado or any other state.

Whole Body Health Center
780 Simms Ste.102
Golden, CO 80401
303.232.2600

FEE SCHEDULE:
Initial intake (1 ½ hr) --- \$85
Return Visit (1 hr) ---- \$65

I have read and understand this form

Signature _____ Date _____

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the above terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.