Acupuncture and Herb Clinic of Rhonda Feiman

Doctor of Asian Medicine

P.O.Box 233, Belfast, ME 04915 *Tel: 207-338-4454*

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 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:_____

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

_____

_____

_____

_____

_____

_____

Significant Trauma (physical or emotional):

_____

_____

_____

Birth History (prolonged labor, forceps delivery, complications):

_____

_____

Surgeries (please include dates):

Allergies (chemical, environmental, food, drugs, etc):

Medications (names & dosages):

Vitamins/Supplements/Herbs:

Exercise (type, days per week, length of workout):

Diet:

Meals per day _____ Snacks_____ Caffeinated drinks_____ Alcohol per week_____

What makes your condition better?

_____

_____

_____

What makes your condition worse?

_____

_____

_____

Personal History Please check all that apply right now.

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

Family Medical History *Please check any that apply to a family member. Put an F (father), M (mother), S (sister), B (brother), GF (grandfather), GM (grandmother) next to the choice.*

- ☐ High Blood Pressure _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Seizures _____
- ☐ Asthma _____
- ☐ Stroke _____
- ☐ Allergies _____
- ☐ Heart Disease _____
- ☐ Other _____
_____
_____
_____

Please check if you have had any of these items listed below in the last year. Put a star on the box if you have had this in the past but do no longer.

General:

- ☐ Poor appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ General fatigue
- ☐ Poor sleeping
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Weight gain/loss
- ☐ Sudden energy drop
- ☐ Sweats easily
- ☐ Poor balance
- ☐ Peculiar taste/smells
- ☐ Strong thirst (hot/ cold)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair:

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

Head, Eyes, Ears, Nose and Throat:

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in Ears
- ☐ Nose Bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Poor Hearing
- ☐ Recurrent sore throat/colds
- ☐ Dental Problems
- ☐ Migraines
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Spots in front of eyes
- ☐ Grinding Teeth
- ☐ Jaw clicks/locks
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial Pain
- ☐ Headaches

Cardiovascular:

- ☐ Chest pain or pressure
- ☐ Cold hands /feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heartbeat
- ☐ 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
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Difficult to inhale/exhale
- ☐ Pain with deep inhalations
- ☐ Tight sensations in chest
- ☐ Difficult breathing when lying down
- ☐ Production of phlegm: what color?_____

Gastrointestinal:

- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating/Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad Breath
- ☐ Chronic laxative use
- ☐ Acid Reflux/GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Loose stools (>2xday)
- ☐ Hernia
- ☐ IBS/Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite

Genito-Urinary:

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Dribbling after urination
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Night urination
  - what time?_____
  - how often?_____
- ☐ Burning urination
- ☐ Blood in urine
- ☐ Copious flow
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Sores on genitals
- ☐ Pain in testicles
- ☐ Prostatitis
- ☐ Herpes
- ☐ Infections
- ☐ Kidney Stones
- ☐ Decreased libido
- ☐ Excessive libido
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission

Gynecological/Reproductive:

- ☐ PMS
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Fibrocystic breast tissue
- ☐ Polycystic ovarian disease
- ☐ Irregular menstruation
- ☐ Painful menstruation
- ☐ Difficult/painful intercourse
- ☐ 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__
- ☐ Number of abortions __

Musculoskeletal:

- ☐ Neck pain
- ☐ Knees pain
- ☐ Hip pain
- ☐ Back pain low
- ☐ Back pain middle
- ☐ Back pain upper
- ☐ Shoulder pain
- ☐ Sprains/Strains
- ☐ Muscle pain
- ☐ Hand/wrist pain
- ☐ Sciatica
- ☐ Muscle weakness
- ☐ Bursitis
- ☐ Carpal Tunnel
- ☐ Foot/ankle pain
- ☐ Tendonitis
- ☐ Rotator cuff

Soreness/weakness in:

- ☐ back
- ☐ knee
- ☐ hip
- ☐ ankle
- ☐ foot

Neuropsychological:

- ☐ Seizures
- ☐ Lack of coordination
- ☐ Anxiety/Panic attacks
- ☐ Nervousness
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Bad temper/irritability
- ☐ ADD/ADHA
- ☐ Vertigo/dizziness
- ☐ Concussion
- ☐ Manic depression
- ☐ Areas of numbness
- ☐ Depression
- ☐ Seasonal Affective Disorder
- ☐ Easily susceptible to stress

Comments: Please inform me of any other problems you would like to discuss.

_____

_____

_____