# Associates For Creative Wellness, Inc. ®
## Associates For Asian Healing Arts

The Pavilions at Greentree, 651 Route 73 North, Suite 306, Marlton, NJ 08053
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HEALTH QUESTIONNAIRE

Date _____

Name_____ Age_____Birth Date _____ Sex ____

Street Address_____

City _____State _____Zip _____

Home Phone _____ Occupation _____Work Hours _____

Work Phone _____Employer Address _____

Email _____Cell phone_____

Referred by _____

MARITAL STATUS
Single _____ Widowed _____
Married _____ Separated _____
Divorced ____ Partnered _____

Have you ever been examined by me before? _____

Presenting Problem: _____
_____
_____
_____
_____

Current or recent M.D.,D.O., or D.C.'s name and diagnosis and diagnostic code _____
_____

Do you have any pain? Please describe how it feels to you. _____
_____

How is your energy?_____
How do you feel emotionally?_____

Please describe in detail your dietary habits.
What did you eat yesterday? Breakfast _____
Lunch _____
Dinner _____
Snacks _____

Is this typical? _____

If not, what is different? _____

List all allergies: _____

Did you ever smoke? _____ Do you smoke now?_____ How many a day? ____ How many years?_____

Do you use alcoholic beverages? How often per day/week/month?_____

Have you ever been treated for:
Mental Illness? _____ Fracture?_____ Head Injury? _____

Explain treatment _____

How many hours do you sleep nightly? _____ Do you waken feeling rested? _____
Describe any difficulty. _____

Do you have a form of regular exercise? Describe. _____

List all current medications, supplements and topicals: _____

Anything significant about your birth? (C-section /premature /mutiple, other). _____

Family History: (Cancer, diabetes, high blood pressure, heart disease, stroke, allergy, asthma, alcoholism, TB, other) (Circle any that apply). _____
Mother: (Age now/Age dec'd.)_____ Grandparents (Ages now/dec'd)_____
Father: (Age now/Age dec'd.) _____
Siblings:(#, Ages) _____ Children (#, Ages) _____

| | Most Preferred | Least Preferred |
|---|---|---|
| Colors | | |
| Season | | |
| Weather | | |
| Time of Day | | |
| Flavor (bitter, salty, sour, spicy, sweet) | | |

Where do you hold tension? _____ What does it feel like? _____

What do you do for relaxation? _____

| PAST MEDICAL HISTORY | | | |
|---|---|---|---|
| Have you had: | __Measles | __Mumps | __Whooping Cough |
| | __ Chicken Pox | __Scarlet Fever | __Diphtheria |
| | __ Rheumatic Fever | __Diabetes Mellitus | __ Poliomyelitis |
| ___ HIV | __ Tuberculosis | __ Hepatitis | __ Lyme's Disease |

Any other illness(es)?

Describe hospitalization(s): Include type of surgery (tonsils, adenoids, gall bladder, broken bones, c-section, etc.) or specific illness(es) and dates.

Fluids

Do you have mucus_____Where and when?_____
Do you perspire easily/never/sweat spontaneously? (Circle one) Odor? _____
How many times a day do you urinate? _____ Odor? _____ Color? _____ At night? _____
Any vaginal/penile secretions? _____Odor? _____ Color? _____

Any breast secretions? If yes, describe._____

DIRECTIONS: If you can answer YES to the question asked, put a circle around the YES. If you can answer NO to the question asked, put a circle around the NO.

**EYES, EARS, NOSE, THROAT**

Are you hard of hearing? YES NO
Do you have constant noises in your ears? YES NO If yes, describe _____
Have you at times had bad nosebleeds? YES NO If yes, how recent ?_____
Do you suffer from a constantly runny nose? YES NO
Do your eyes continually blink or water? YES NO
Do you have dry eyes? YES NO
Do you often see spots before your eyes? YES NO If yes, describe _____
Is your vision poor? (i.e. Do you need glasses/contacts)? YES NO
Are you nearsighted/farsighted? YES NO
Do you often have pain in your eyes? YES NO
Do you suffer from frequent sore throats? YES NO
Do you suffer from frequent earaches? YES NO

**RESPIRATORY**

Do you frequently suffer from heavy chest cold? YES NO
Do you suffer from asthma? YES NO
Are you troubled by constant coughing? YES NO
Have you ever coughed up blood? YES NO
Have you ever had TB (tuberculosis)? YES NO
Do you have any chronic chest condition? YES NO If yes, describe _____
Do you often have pain in your chest when taking deep breaths? YES NO If yes, describe _____

**CARDIOVASCULAR**

Have you ever been told you had heart trouble? YES NO If yes, describe _____
Do you have pains in your heart or chest? YES NO
Does exercise or excitement cause you to have pains in the chest? YES NO
Are you often bothered by thumping of the heart? YES NO
Has a doctor ever said your blood pressure was too low? YES NO How low ___
Has a doctor ever said your blood pressure was too high? YES NO How high? ___ w/med___ w/o med____
Do you often have difficulty breathing? YES NO
Do you often have to stop for breath when walking up stairs? YES NO
Have you ever had to sit up to catch your breath? YES NO
Are your ankles often badly swollen? YES NO
Has a doctor ever said you had varicose veins? YES NO

**GASTROINTESTINAL**

Have you had a recent unexplained loss of weight? YES NO
Is your appetite usually poor? YES NO
Do you usually belch a lot? YES NO
Do you usually pass a lot of gas by rectum? YES NO
Do you suffer from indigestion? YES NO If yes, describe _____
Do you suffer from frequent loose bowel movements (diarrhea)? YES NO
Are you constantly constipated? YES NO
How many bowel movements daily or weekly? (Circle daily or weekly)_____
Do you frequently have severe stomach pains? YES NO
Do you have frequent vomiting? YES NO
Have you ever vomited blood? YES NO
Have you ever passed blood with your bowel movement? YES NO If yes, how recently?_____

**GENITOURINARY**

Do you have trouble holding your urine? YES NO
Have you ever dribbled urine when sneezing? YES NO
Have you ever had blood or gravel in your urine? YES NO
Do you often have pain or burning on urination? YES NO
Have you ever had a kidney disease? YES NO
Are you having trouble starting your stream when you urinate? YES NO

How is your energy sexually? _____ Poor _____ Good ____ Excellent
Are sexual relations painful or difficult for you? YES NO
Have you had a recent loss of interest in sexual relations? YES NO
What form of birth control do you use? _____

**SKIN and EXTRMETIES**
Have you had arthritis or rheumatism? YES NO
Are your joints often painfully swollen? YES NO
Do you frequently get severe leg cramps when walking? YES NO at night? YES NO
Do you have any skin rashes? YES NO
Describe any scars and how acquired. _____

**NEUROMUSCULAR**
Do you suffer from frequent severe headaches? YES NO
Are you usually nervous? YES NO
Do you often have spells of severe dizziness? YES NO
Do you frequently feel faint? YES NO
Have you had a loss of strength or feeling in any part of your body? YES NO
Was any part of your body ever paralyzed? YES NO
Have you ever had a fit or convulsion (epilepsy)? YES NO

**HEMATOLOGY**
Do you bruise more easily than normal? (estimate) YES NO
When you cut yourself do you bleed excessively? YES NO
Do you have a history of anemia (low blood count)? YES NO

**ENDOCRINE**
Do you have a history of thyroid trouble? YES NO
Were you ever given thyroid tablets to take? YES NO
Do you have any lumps or bumps anywhere in your body? YES NO

**WOMEN: OBSTETRICS & GYNECOLOGY**
How old were you when you started menstruating? _____
Are your periods usually regular? YES NO
When did your last period begin? _____
Usual # of days of flow _____ Usual # of days of cycle _____
Amount of flow _____ Color _____ Clotting? _____ Color & size of clots. _____
Please describe any discomfort before flow _____
During period _____
Have you ever had vaginal bleeding between your menstrual periods? YES NO
How many children had you had? _____
Have you had a miscarriage? YES NO How many? _____
Do you have vaginal burning, itching or dryness? YES NO
Have you ever had a bloody nipple discharge? YES NO

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**OFFICE POLICY - Please Read and Sign**

I understand that payment is due at the time of treatment.

_____
**Signature** **Date**

**Authorization to Release Information**
I hereby authorize Associates for Creative Wellness to release any information acquired in the course of my examination or treatment if requested by me for my health care practitioners or required by law.

_____
**Signature** **Date**

**I understand that this office does not overbook appointments and that last-minute cancellations or no-shows cause a problem for the acupuncturist and for other patients, and I agree to pay 1/2 the appointment fee for any appointment I miss without notifying the office at least 24 hrs. before the scheduled time._**

**Signature**_____