Sedona Acupuncture

Robert Abrahamson OMD L.Ac

1785 W. State Route 89A, Suite 3D
Sedona, AZ 86336 • (928) 204-0595
AZ License # 0170 • EIN # 20-3971774
info@sedona-acupuncture.com

Patient Questionnaire

This is a confidential report.
Your honest evaluation is needed in order to accurately access your health status, and effectively work with you.

Today's Date: _____

Last name _____ First name _____ Age _____

Address _____ Birth date _____

City _____ Zip _____ Occupation _____

Home phone _____ Cell phone _____ Insurance _____

Email _____

Referred by _____

What is the main reason you have come for acupuncture and/or medicinal herbs?

Give a brief history of this condition from the onset to the present. Include any treatments you have received and any medication taken. What has helped? What has not helped?

Are you presently under a Doctor or Health practitioner's care? If so, who?

Approximate date of last medical exam _____

Are there any secondary conditions which you would like treated?

List any medications, including herbal or homeopathic, that you are taking for this or any other medical condition.

If you have ever been hospitalized, list the dates and reason for each: include any surgery, broken bones, concussion, etc.

List any acute conditions you have had in the past year, e.g. colds, flu, shingles, injuries.

List any unusual childhood diseases you have had, including any allergies.

H HAVE HAD WITHIN THE PAST YEAR
F HAVE FREQUENTLY

EXAMPLE: **F** Low back pain
If you have frequent low back pain

___Low back pain
___Tingling, numbness in extremities
___Painful urination
___Frequent nighttime urination
___Night sweats
___Tinnitis/ear ringing
___Impaired hearing
___Hair thinning/loss
___Impotence
___Constipation
___Diarrhea
___Flatulence
___Hemorrhoids
___Blood in stools
___Heartburn/GERD
___Abdominal pain
___Stomach bloated after meals
___Nausea/vomiting
___Sores on tongue or in mouth
___Bad breath
___Teeth problems
___Bleeding gums
___Increased thirst
___Difficulty swallowing
___Loss of appetite
___Food or drug allergies
___Shortness of breath
___Irregular heart beat
___Palpitations
___Cold hands or feet
___Fainting
___Varicose veins
___Chest pain
___Leg cramps
___Headache
___Blurred vision
___Anemia
___Ankles swollen
___Frequent colds
___Excessive sweating
___Easily tired
___Dry cough
___Sore throat
___Cough with phlegm
___Hay fever
___Sinusitis
___Excessively dry skin
___Warts or boils
___Acne
___Itching/hives
___Rashes/eczema
___Psoriasis
___Painful or swollen joints
___Muscular pains
___Tight neck or shoulders
___Easily bruise
___Bitter, metallic taste in mouth
___Eyelids puffy
___Eyes red or dry
___Insomnia
___Sleap apnea
___Depression
___Irritability/moodiness
___Nervousness
___Claustrophobia
___Limbs feel heavy or weak
___Morning fatigue
___Afternoon fatigue
___Dizziness/Vertigo
___Forgetfulness
___Brittle nails
___Pains under ribs
___Lymph node enlargement
___Grind teeth at night
___TMJ
___Low blood pressure
___Thyroid problems
___Hypoglycemia

HAVE YOU EVER HAD:

___Kidney stones
___Coma or concussion
___Ulcer
___Blood transfusion
___Gallstones
___Rheumatic fever
___Scarlet fever
___Pneumonia
___Pleurisy
___Tuberculosis
___Polio
___Epilepsy
___Diabetes
___Herpes. Which type?___
___Hernia
___Jaundice
___Hepatitis A, B or C (circle one)
___Heart murmur
___Heart attack
___Heart disease
___Tumor or cyst
___Kidney infection
___Protein in urine
___Venereal disease
___Drug or narcotic habit
___Cancer
___HIV/AIDS
___Prostate enlargement
___High blood pressure
___Asthma
___Migraines
___Arthritis
___Nervous breakdown
___Prolonged course of antibiotics
___Prolonged course of steroids
___Excessive alcohol habit
___Lyme Disease
___Shingles
___Parasites

DO YOU:

___Get enough sleep
___Eat regular meals
___Exercise regularly
___Have a stressful job
___Smoke cigarettes___(how many)
___Prefer cold drinks
___Prefer warm drinks
___Have dental amalgams
___Have environmental sensitivities

WOMEN ONLY:

___Pregnancies (how many)
___Abortions, miscarriages (how many)
___Caesarian sections (how many)
___Yeast or vaginitis
___Painful menses
___Uterine cyst
___Breast tenderness/lumps
___Ovarian cyst
___Clots or dark menses
___Consistently light or heavy flow
___Pre-menstrual syndrome
___Mood swings
___Hot flushes/night sweats
___Endometriosis
___Water retention
___Pelvic inflammatory disease
___Birth control pills (how many years)___
___Are you pregnant or nursing?
Age at onset of Menstruation/ Menopause_____
Interval between periods_____
Duration of periods_____
Approx. date of last period_____
Approx. date of last Pap test_____
Present form of birth control
_____

Is there a time of day when you feel most energetic?_____Least energetic?_____

Are you happy with your general energy level (physical/mental/sexual)?_____

Are you able to express your feelings? _____

What are three factors in your life that seem most important to your daily health?_____

Is there anything else you want to bring to the attention of the doctor?_____

WHO IN YOUR FAMILY HAS A HISTORY OF THE FOLLOWING?

Cancer _____

_____(specify location)_____

Diabetes_____

Arthritis_____

Heart disease_____

High blood pressure_____

Depression_____

Mental illness_____

Asthma_____

Migraine_____

Allergies_____

Osteoporosis_____

Ulcer_____

Epilepsy_____

Colitis_____

Others, please list_____

_____

_____

DIET AND NUTRITION

Daily	Occasionally	Rarely	Never	DO YOU EAT:	Daily	Occasionally	Rarely	Never	WHICH % YOU EAT:
				__Vegan					Organic foods_____%
				__Gluten Free					Commercially grown foods_____%
				__Raw					
				Fresh fruits					White or brown sugar products
				Fresh vegetables					Artificial sweeteners
				Raw foods					Fried foods
				Sprouted foods					Fast foods
				Whole grains					Pre-packaged/processed foods
				Wheat products					Carbonated drinks
				Legumes/Beans					Chocolate
				Nuts & Seeds					Green/black tea _____ cups/day
				Dairy products					Coffee _____ cups/day
				Peanut butter					Water_____ cups/day
				Fermented foods					Beer/Wine
				Eggs					Liquor
				Fish					Marijuana
				Poultry					Aspirin/Pain killers
				Red meats/Cold cuts					Laxatives
				White flour products					Other drugs

Please list all vitamins, mineral or other nutritional supplements you are now taking.

_____

_____

Thank you for your time