EastWest HealthWorks, Inc

978-256-9499

DATE_____
NAME_____
First Middle Last
ADDRESS_____
_____
HOME PHONE_____WORK PHONE_____
CELL PHONE_____E-MAIL_____
MARITAL STATUS: D W M S AGE:_____
OCCUPATION_____
HEIGHT_____ WEIGHT_____ DOB_____
INSURANCE_____
ADDRESS_____
POLICY NUMBER_____GROUP #_____
SUBSCRIBER NAME_____ DOB_____
FAMILY PHYSICIAN_____
PHONE NUMBER_____
EMERGENCY CONTACT_____
PHONE NUMBER_____
REFERRED BY_____
Have you been treated with Acupuncture or Oriental Medicine? O yes O no If yes, what style?_____
MEDICATIONS DOSE REASON
_____
_____
_____
_____
_____
_____
_____

The following pages ask for information about your health. This information helps us provide you with the highest quality health care. However, if you are uncomfortable with any part of it you may skip it. If you have any questions or concerns please feel free to ask.

Your privacy is of great importance to us. Our privacy policy is spelled out in detail in the last section of this questionnaire.
Thank you.

What is the main problem or concern you would like help with?

_____

_____

How long ago did this problem begin? (Please be specific)_____

_____

Have you been given a diagnosis for this problem ? If so, what is the diagnosis and by whom was it given?_____

_____

To what extent does this problem interfere with daily life? _____

_____

On a scale of 1-10 where 1 is as good as it could be and 10 being as bad as it gets:

How much does this problem bother you?_____

What other kinds of treatment have you received for this problem? Medication, Acupuncture, Herbs, Massage, Chiropractic, Physical Therapy, Reiki, Homeopathy, Other__

_____

Do you have secondary problems or concerns you would like help with?

_____

_____

PERSONAL MEDICAL HISTORY OF SIGNIFICANT ILLNESS

Arthritis	Asthma	Kidney Disease	Depression
Stroke	Allergies	Ulcer	Anxiety
Heart Disease	Sinus problems	Thyroid Disease	Seizures
Hypertension	Headaches	Venereal Disease	Diabetes

Cancer Type_____

Other_____

HOSPITALIZATIONS/SURGERIES

DATE PROCEDURE REASON

_____

_____

_____

_____

____

SIGNIFICANT EMOTIONAL AND/OR PHYSICAL TRAUMA (Auto accident, fall, divorce, etc.)

DATE TRAUMA

_____

_____

_____

FAMILY MEDICAL HISTORY

Stroke Asthma Kidney Disease Depression

Heart Disease Allergies Ulcer Anxiety

Hypertension Sinus Thyroid Disease Arthritis

Diabetes Seizures Venereal Disease Headaches

Cancer Type_____

Other_____

HEALTH HABITS

Describe

Stress Mild _____

	Moderate _____	
	Severe_____	
Exercise	Yes_____	
	No_____	
Diet	Traditional_____	
	Vegetarian_____	
	Vegan_____	
	Celiac_____	
	Medically Related_____	
	Other_____	

Describe your average daily diet

Morning	Afternoon	Evening	Snacks

Tobacco	How much per day	How long have you
Smoke	_____	_____
Chew	_____	_____

Caffeine	# of cups per day
Coffee	_____
Tea	_____
Colas	_____

How many 8 oz glasses of water do you drink? _____

How many alcoholic drinks do you have each week? _____

Do you use drugs for non-medical reasons? yes no

Describe_____

Please check if you have had any of the following symptoms in the last three months:

GENERAL

Fever Chills Fatigue Sweat easily

Poor sleeping Night sweats Weight loss Cravings

Weight gain Change in appetite Strong thirst for hot cold

Sudden energy drop, if so what time of day?_____

Bleed or bruise easily Peculiar tastes or smells

SKIN & HAIR

Rashes Ulcerations Hives Itching

Eczema Pimples Dandruff Loss of hair

Recent Moles Psoriasis Dermatitis Acne

Change in hair or skin texture Other_____

HEAD, EYES, EARS, NOSE & THROAT

Dizziness Concussions Migraines Night Blindness

Glasses Eye strain Eye pain Color Blindness

Cataracts Poor Vision Blurry vision Spots in vision

Earaches Poor hearing Sinus problems Ringing in ears

Nose bleeds Grinding teeth Clenching jaw Chronic sore throat

Jaw clicks Facial pain Teeth problems Sores on lips/tongue

Headaches, where & when?_____

Other head or neck problem?_____

CARDIOVASCULAR

High blood pressure Low blood pressure Chest pain
Irregular heart beat Difficulty breathing Blood clots
Cold hands or feet Swelling of hands Swelling of feet
Varicose of spider veins Palpitations at rest Palpitations
Phlebitis Fainting
Other heart or blood vessel problem_____

RESPIRATORY

Cough Coughing Blood Bronchitis Chest tightness
Asthma Pain with breathing Pneumonia
Difficulty breathing when lying down
Phlegm, what color_____

GASTROINTESTINAL

Nausea Vomiting Blood in stools Black stools
Gas Belching Bloating/edema Constipation
Diarrhea Indigestion Rectal pain Hemorrhoids
Hernia Bleeding gums Food stagnation Poor appetite
Colitis Slow digestion Excessive appetitie Loose stools
Bad breath IBS/Chrohns Abdominal pain Reflux/GERD
Chronic laxative use Other_____

GENITO-URINARY

Frequent urination Blood in urine Urgency to urinate
Pain upon urination Decrease in flow Kidney stones
Sores on genitals Unable to hold urine Impotency
Color of urine_____
Do you wake at night to urinate? yes no How many times?

Other genital or urinary problems?_____

REPRODUCTIVE & GYNECOLOGIC (women)

Are you pregnant? yes no

Is it possible you are pregnant? yes no

Number of pregnancies:____Live Births:____Miscarriages____

Abortions_____ Premature Births:_____

Age at first menses:_____ Last PAP:_____

Duration of menses:_____ Time between menses:_____

Irregular periods Painful periods Clots Breast lumps

Vaginal dryness Vaginal discharge Endometriosis

Uterine Fibroids Vaginal sores

Polycystic Ovarian Ds Fibrocystic Breast Disease

Unusual character of blood (heavy, scanty)_____

Do you practice birth control? yes no If yes what type?___

MUSCULOSKELETAL

Neck pain Rotator cuff Knee pain Foot/ankle pain

Muscle pain Muscle spasm Shoulder pain Muscle weakness

Hip pain Sciatica Bursitis Carpal tunnel

Sprains/strains Tendonitis Hand/wrist pain

Back pain: Low____ Middle____ Upper____

Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PSYCHOLOGICAL

Seizures Dizziness Loss of Balance Areas of numbness

Anxiety Concussion Poor Memory Poor coordination

Depression Bad temper ADD/ADHD Nervousness

Manic depression Easily susceptible to stress

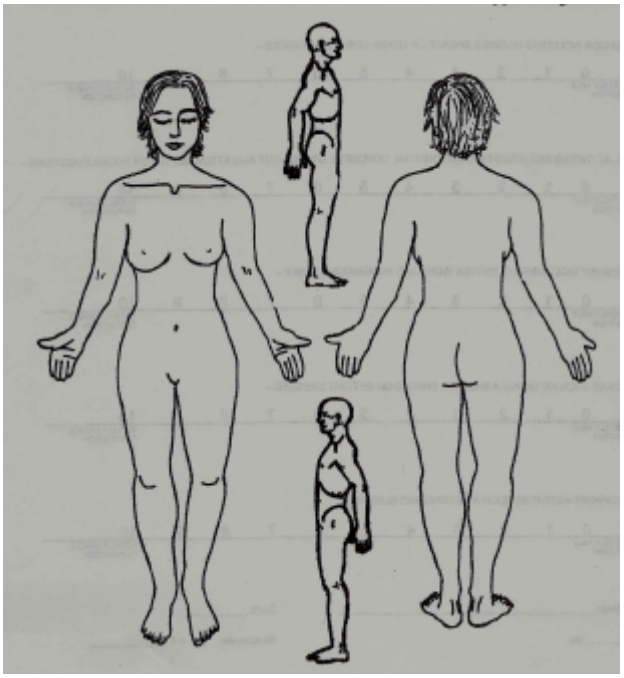
Have you ever been treated for emotional problems? yes no

Have you ever considered or attempted suicide? yes no

Any other neurological or psychological problems?_____

_____

Please indicate any painful or distressed body areas by circling the particular



COMMENTS: Tell us briefly of any other problems you would like to discuss.

_____

_____

_____

_____

_____

_____

_____