

Health Quest Acupuncture, Monika Kobylecka, L.Ac.

Santa Clarita ~ 661. 904. 6919 Santa Monica ~ 310.230.5533

www. HQacupuncture .com

This is a **CONFIDENTIAL** questionnaire that will be used to determine the best treatment plan for you.

Date

First name

Last name

Home address

Home phone

Alternate phone

Email address

DOB:

Age:

Female

Male

Height:

Weight:

Have you ever had acupuncture?

no

yes... when?

With whom?

How did you hear about Health Quest Acupuncture?

Is there someone we can thank for referring you?

Emergency contact name

Relationship to you

Emergency contact phone

Please note: *We do not accept insurance but we will provide you with a receipt that you can submit to your insurance company. Please contact your provider to determine if they will reimburse you for your acupuncture treatments. By checking the box below you acknowledge that you are responsible for all your payments at the time of service.*

I acknowledge that I have read and accept the above statement

Describe the reason(s) for which you are seeking acupuncture?

What other treatment(s) have you tried for this complaint?

Please list any surgeries, accidents, hospitalizations and illnesses you've had as a child (include problems during birth): Write down DATE first followed by DESCRIPTION.

Please list any surgeries, accidents, hospitalizations and illnesses you've had as an adult: (women please list C-sections and tubal ligations/tubes tied; men please list vasectomy and hernia operations) Write down DATE first followed by DESCRIPTION

Do you have any scars; even minor ones, from surgeries or injuries? Please note the location(s):

Please list all medications, supplements, herbs, vitamins and minerals you are currently taking:

Do you have any known allergies? no yes To what?

Do you have a pacemaker? no yes Date of surgery?

Are you taking Cumadin/ Warfarin? no yes

Are you taking Eskalith, Lihobid, Lithonate, Lithotabs? no yes

Have you traveled out of the country in the last 2 years? no yes

Did you require special vaccines? no yes If "yes" please list:

FEMALE PATIENTS ONLY:

Are you pregnant? no yes

Are you nursing? no yes

Number of live births:

Number of abortions:

Number of miscarriages:

Age when you had your first period (menarche)?

Number of days between periods?

Are your periods regular? no yes

Number of days of flow?

Date of your last gynecological exam?
 yes

Have you ever had an abnormal Pap smear? no

Do you use birth control? no yes What type?

Have you been diagnosed with one or more of the following? (mark all that apply):

- | | |
|--|--|
| <input type="checkbox"/> fibroids | <input type="checkbox"/> PID |
| <input type="checkbox"/> endometriosis | <input type="checkbox"/> infertility |
| <input type="checkbox"/> ovarian cysts | <input type="checkbox"/> blocked fallopian tubes |

Do you have any of the following symptoms associated with your menstrual cycle? If yes, please indicate when it occurs:

- | | | | |
|--|---------------------------------|---------------------------------|--------------------------------|
| <input type="checkbox"/> Pain | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |
| <input type="checkbox"/> Aching | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |
| <input type="checkbox"/> Consistent pain | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |
| <input type="checkbox"/> Intermittent pain | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |
| <input type="checkbox"/> Low back area | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |
| <input type="checkbox"/> Abdominal area | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> before | <input type="checkbox"/> during | <input type="checkbox"/> after |

Other symptoms related to menses. Check all that apply.

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Constipation | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Swollen breasts | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Headache | |
| | | <input type="checkbox"/> Diarrhea | |

Date of last mammogram?

Age when menopause symptoms started:

Age when you had your last period:

Do you have any of the following symptoms associated with menopause?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Constipation | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Changes in mood | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Headaches | | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Back pain |

Mark the boxes that correspond with your current symptoms (NOW column) and symptoms you have had in the past but are **not** experiencing now (PAST column).

Now	Past	SKIN
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis
<input type="checkbox"/>	<input type="checkbox"/>	Fungal infections
<input type="checkbox"/>	<input type="checkbox"/>	Warts
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily

Now	Past	GASTROINTESTINAL
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	No appetite
<input type="checkbox"/>	<input type="checkbox"/>	No appetite for breakfast
<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Gas
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel
<input type="checkbox"/>	<input type="checkbox"/>	Ileocecal valve spasm
<input type="checkbox"/>	<input type="checkbox"/>	Peritonitis
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	Polyps
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	GI tumors

Now	Past	HEART & CIRCULATION
<input type="checkbox"/>	<input type="checkbox"/>	Fast pulse (over 100 beats/min)
<input type="checkbox"/>	<input type="checkbox"/>	Slow pulse (less than 60 beats/min)
<input type="checkbox"/>	<input type="checkbox"/>	Irregular pulse
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Pressure in the chest
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Chest pains
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Cold sweats
<input type="checkbox"/>	<input type="checkbox"/>	Feel dizzy when stand up too quickly or stand for a long time
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands and feet
<input type="checkbox"/>	<input type="checkbox"/>	Flushed face
<input type="checkbox"/>	<input type="checkbox"/>	Raynaud's disease

Now	Past	RESPIRATORY
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Cough

<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Lung abscess

Now	Past	EAR, NOSE, THROAT & MOUTH
<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ringing in the ears)
<input type="checkbox"/>	<input type="checkbox"/>	Itchy ears
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections
<input type="checkbox"/>	<input type="checkbox"/>	Ear pain
<input type="checkbox"/>	<input type="checkbox"/>	Sinus headaches
<input type="checkbox"/>	<input type="checkbox"/>	Stuffy nose
<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal-drip
<input type="checkbox"/>	<input type="checkbox"/>	Runny nose
<input type="checkbox"/>	<input type="checkbox"/>	Throat glands swell easily
<input type="checkbox"/>	<input type="checkbox"/>	Strep throat infections
<input type="checkbox"/>	<input type="checkbox"/>	Dry throat
<input type="checkbox"/>	<input type="checkbox"/>	Itchy throat
<input type="checkbox"/>	<input type="checkbox"/>	Throat infections
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Changes in voice – frog voice
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>	<input type="checkbox"/>	Periodontitis
<input type="checkbox"/>	<input type="checkbox"/>	Dental abscess
<input type="checkbox"/>	<input type="checkbox"/>	Mumps
<input type="checkbox"/>	<input type="checkbox"/>	Inflammation of the mouth
<input type="checkbox"/>	<input type="checkbox"/>	TMJ pain
<input type="checkbox"/>	<input type="checkbox"/>	Canker sores
<input type="checkbox"/>	<input type="checkbox"/>	Cold sores

Now	Past	HORMONAL
<input type="checkbox"/>	<input type="checkbox"/>	Low thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Overactive thyroid
<input type="checkbox"/>	<input type="checkbox"/>	Hashimoto's disease (thyroid)
<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	<input type="checkbox"/>	Blood sugar problems
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Lupus (SLE)
<input type="checkbox"/>	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease

Now	Past	GENERAL
<input type="checkbox"/>	<input type="checkbox"/>	Food allergies
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Low immunity
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Exhaustion
<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems (irritable, depressed, anxious)

<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating
<input type="checkbox"/>	<input type="checkbox"/>	Easily get sea sick/car sick
<input type="checkbox"/>	<input type="checkbox"/>	Unusual or excessive sweating
<input type="checkbox"/>	<input type="checkbox"/>	Lack of sweating
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Bladder infections
<input type="checkbox"/>	<input type="checkbox"/>	UTIs (urinary track infections)

Now	Past	INFLAMMATORY
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Connective tissue disease
<input type="checkbox"/>	<input type="checkbox"/>	Tendinitis
<input type="checkbox"/>	<input type="checkbox"/>	Plantar fasciitis
<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	Myofascial pain
<input type="checkbox"/>	<input type="checkbox"/>	Constant slight fever

Now	Past	MALE
<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Premature ejaculation
<input type="checkbox"/>	<input type="checkbox"/>	Prostate gland problems
<input type="checkbox"/>	<input type="checkbox"/>	Infertility

Now	Past	Neurological
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Memory loss

Now	Past	MUSCLE/JOINT
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Weak muscles
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking
<input type="checkbox"/>	<input type="checkbox"/>	Shooting pain

Now	Past	OTHER
<input type="checkbox"/>	<input type="checkbox"/>	No energy even with lots of rest/sleep
<input type="checkbox"/>	<input type="checkbox"/>	Feel spacey
<input type="checkbox"/>	<input type="checkbox"/>	Scattered mind
<input type="checkbox"/>	<input type="checkbox"/>	Excess energy at night
<input type="checkbox"/>	<input type="checkbox"/>	Smoke cigarettes
<input type="checkbox"/>	<input type="checkbox"/>	Drink alcohol more than 4 times per week
<input type="checkbox"/>	<input type="checkbox"/>	Use marijuana
<input type="checkbox"/>	<input type="checkbox"/>	Use other recreational drugs