

Connecting Point

A Community Acupuncture Center

20 Yossi Ben Yoezer St., Jerusalem

Tel: Roy- 050-3007209 ; Yael- 050-8935359 ; Esther- 054-4273090 ; Esti- 050-3320607

www.dikur.net



Health History Questionnaire

Patient Information	Contact Information
<p>Date: _____</p> <p>Name: _____</p> <p>Address: _____</p> <p>Age: _____ Birth date: _____</p> <p>Occupation: _____</p> <p>How did you hear about us? _____</p> <p>_____</p> <p>_____</p>	<p>Home Phone: _____</p> <p>Cell Phone: _____</p> <p>Email: _____</p> <p>Another person we may contact if needed:</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Phone: _____</p>
Health History	
<p>What are your primary concerns for coming in for treatment?</p> <p>1- _____</p> <p>2- _____</p> <p>3- _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries: _____</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives:</p> <ul style="list-style-type: none"><input type="checkbox"/> Diabetes<input type="checkbox"/> High blood pressure<input type="checkbox"/> Stroke<input type="checkbox"/> Cancer<input type="checkbox"/> Heart disease<input type="checkbox"/> Kidney disease	<p>Check symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"><input type="checkbox"/> Depression<input type="checkbox"/> Difficulty in focusing<input type="checkbox"/> Dizziness<input type="checkbox"/> Easily startled<input type="checkbox"/> Excessive worry<input type="checkbox"/> Excessive Anger<input type="checkbox"/> Excessive fear<input type="checkbox"/> Fatigue/tiredness<input type="checkbox"/> Headaches<input type="checkbox"/> Loss of sleep/poor sleep<input type="checkbox"/> Loss or gain of weight<input type="checkbox"/> Nervousness/irritability<input type="checkbox"/> Overwhelmed by life <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"><input type="checkbox"/> Aids<input type="checkbox"/> Allergies<input type="checkbox"/> Anemia<input type="checkbox"/> Arthritis<input type="checkbox"/> Bleeding disorders<input type="checkbox"/> Breast lump<input type="checkbox"/> Cancer<input type="checkbox"/> Diabetes<input type="checkbox"/> Heart disease<input type="checkbox"/> High Cholesterol <p>Is there a medical diagnosis to what you suffer from?</p> <p>_____</p> <p>_____</p> <p>_____</p>

Check symptoms you have or have had in the last year:

Muscle/Joint/Bones

- Tremors /cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms or hips
- Back
- Legs/feet
- Neck
- Hands
- Shoulders
- Other _____

Eyes/Nose/Throat/Respiratory

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

Skin

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

Genito/Urinary

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stone
- Lowered libido

Cardiovascular

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

Gastrointestinal

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

For men only

- Erection difficulties
- Penis discharge
- Prostate trouble

For women only

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms (hot flashes, sweating, dryness, irritability...)
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? _____

Signature

I hereby give my consent to be treated by acupuncture and/or herbs. I am aware that this form of therapy does not substitute any conventional therapy or consultation with a physician, and does not suggest quitting medication or other medical care without consultation. I also understand that there is no guarantee of improvement or cure in my condition.

Date: _____ Signature: _____

In respect for our intention to offer high quality health care at affordable prices, we ask for 24 hours notice in advance of an appointment if it is necessary to cancel an appointment. All appointments that are cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged fully.