Your First Wealth Is Health

DIAMOND STONE
ORIENTAL MEDICINE

Patient History and Health Questionnaire

Name _____ Date _____

Address _____

_____

Cell Phone _____ Home Phone _____ Office Phone _____

Date of Birth _____ Age ____ Weight ____ Height ____ Gender _____

Emergency Contact Name _____ Phone _____

Marital Status _____ Blood Type _____

Primary Health Care Provider _____

Insurance Type _____

Occupation _____ Employer _____

Email Address _____

Referred By _____

Have you ever received acupuncture before? Yes / No

Traditional Chinese Medicine is a system that views the person as a whole. It may not be apparent to you how some of these questions are related to your health problem, but your answers will provide a framework for helping us to understand you as an individual and to effectively treat your condition.

Reason for visit: _____

Medical History (include surgeries, childhood illnesses, extended antibiotic treatment, accidents, occupational stressors)

_____

_____

_____

Family Medical History (include major events of first and second degree relatives)

_____

_____

_____

Are you adopted? Yes / No

Katherine Krumwiede, Licensed Acupuncturist / katherine@diamondstoneom.com / diamondstoneom.com / 612-201-8727
Diamond Stone Oriental Medicine, Inc., 3249 Hennepin Avenue, Suite 150, Minneapolis, MN 55408

Your First Wealth Is Health

DIAMOND STONE
ORIENTAL MEDICINE

Lifestyle

Diet

How is your appetite? Increased / Decreased / No Change

Number of meals per day _____

What tastes/foods do you crave? (please circle all that apply)

Sweet Salty Sour Hot/spicy Bland Crunchy Other:

Daily Diet: ___ Std. American Diet (SAD) ___ Vegetarian ___ Whole Foods

Are you often thirsty? Yes / No If yes, for hot? ___ for cold? ___ room temp? ___

Habits

Alcohol: Yes / No Number of drinks per day or week _____

Tobacco: Yes / No What and how much _____

Coffee: Yes / No Cups/day _____ How big is your cup? _____

Soda: Yes / No Amount/day _____

Sweet Treats: Yes / No Amount/day _____

Stress

Do you feel that your life is stressful? Yes / No

Describe _____

Sleep Habits (please check all that apply)

☐ Hard to fall asleep ☐ Insomnia with indigestion

☐ Restless dreaming ☐ Easy to wake, hard to fall back to sleep

☐ Wake up too early ☐ Wake tired in the morning

Average number of hours of sleep/night _____

Exercise

Do you exercise regularly? Yes / No How often _____

Types of exercise _____

"Exercise ferments the humors, casts them into their proper channels, throws off redundancies and helps nature in those secret distributions, without which the body cannot subsist in its vigor, nor the soul act with cheerfulness."

– Joseph Addison, British Poet/Politician 1672-1719

Your First Wealth Is Health

DIAMOND STONE
ORIENTAL MEDICINE

Please indicate any past or present health complaints by checking the appropriate box and provide a brief explanation if appropriate

Head, Eyes, Ears, Nose, Throat, Mouth

Present	Past	
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Dizziness
☐	☐	Head trauma (concussion, accidents, etc.)
☐	☐	Eye pain
☐	☐	Visual disturbances
☐	☐	Spots/floaters in eyes
☐	☐	Recurrent sore throat
☐	☐	Dry throat
☐	☐	Dry mouth
☐	☐	Lump in throat
☐	☐	Taste in mouth, describe_____
☐	☐	Smelly breath
☐	☐	Excess or deficient saliva/mucous
☐	☐	Receding / bleeding gums
☐	☐	Mercury / amalgam fillings
☐	☐	Sores on lips, tongue or gums
☐	☐	Sinus congestion / infections
☐	☐	Poor hearing / hearing aids
☐	☐	Earaches
☐	☐	Ringing in ears (tinnitus)

Cardiovascular

☐	☐	Heart palpitations (fluttering sensation)
☐	☐	Cold hands/feet
☐	☐	Chest pain/pressure
☐	☐	Fainting
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Elevated cholesterol
☐	☐	Heart attack
☐	☐	Heart surgery
☐	☐	Stroke / TIA
☐	☐	Varicose veins
☐	☐	Enlarged heart
☐	☐	Bruising/bleeding
☐	☐	Anemia

Gastrointestinal

Present	Past	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Abdominal pain or cramps
☐	☐	Belching
☐	☐	Difficulty Swallowing
☐	☐	Gas
☐	☐	Heartburn (acid reflux)
☐	☐	Ulcers
☐	☐	Constipation/diarrhea
☐	☐	Loose stools
☐	☐	Irritable bowel/spastic colon
☐	☐	Black stools
☐	☐	Blood in stool
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Hepatitis
☐	☐	Liver/gallbladder disorder/gallstones
☐	☐	Diabetes
☐	☐	Anorexia
☐	☐	Bulimia

Respiratory

☐	☐	Cough
☐	☐	Bloody sputum
☐	☐	Pain on deep breathing
☐	☐	Production of phlegm, color_____
☐	☐	Asthma
☐	☐	Shortness of breath
☐	☐	Difficult inhalation/exhalation
☐	☐	Emphysema
☐	☐	Nasal discharge
☐	☐	Post nasal drip
☐	☐	Sleep apnea/snoring
☐	☐	Allergies to _____
		_____
		_____

Present Past

Neuromuscular/skeletal

- ☐ ☐ Neck pain
- ☐ ☐ Spinal stiffness / tightness
- ☐ ☐ Upper back pain
- ☐ ☐ Lower back pain
- ☐ ☐ Shoulder pain
- ☐ ☐ Elbow/upper arm pain
- ☐ ☐ Elbow/upper arm numbness/tingling
- ☐ ☐ Wrist pain
- ☐ ☐ Hand pain
- ☐ ☐ Hip/upper leg pain
- ☐ ☐ Hip/upper leg numbness/tingling
- ☐ ☐ Knee/lower leg pain
- ☐ ☐ Knee/lower leg numbness/tingling
- ☐ ☐ Ankle/foot pain
- ☐ ☐ Jaw pain/clenching
- ☐ ☐ Joint swelling/stiffness
- ☐ ☐ Arthritis
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Muscular incoordination
- ☐ ☐ Loss of balance
- ☐ ☐ Weakness
- ☐ ☐ Epilepsy
- ☐ ☐ Numbness/tingling, where _____
- ☐ ☐ Tremor

Neuropsychological

- ☐ ☐ Mood swings
- ☐ ☐ Depression/Anxiety
- ☐ ☐ Drug/alcohol dependence
- ☐ ☐ Seizures
- ☐ ☐ Decreased memory
- ☐ ☐ Lack of concentration
- ☐ ☐ Seasonal Affective Disorder
- ☐ ☐ Startle Easily

Dermatological

- ☐ ☐ Acne
- ☐ ☐ Itching, where _____
- ☐ ☐ Rash / purpura
- ☐ ☐ Eczema / Psoriasis
- ☐ ☐ Nail fungus / Athlete's foot
- ☐ ☐ Excessively dry skin
- ☐ ☐ Hair loss
- ☐ ☐ Dandruff

Present Past

Genitourinary

- ☐ ☐ Pain/burning on urination
- ☐ ☐ Bladder infections
- ☐ ☐ Urgency to urinate
- ☐ ☐ Decrease in flow
- ☐ ☐ Waking at night to urinate
- ☐ ☐ Frequent urination
- ☐ ☐ Delay in starting stream
- ☐ ☐ Loss of bladder control
- ☐ ☐ Color of urine (clear, dark, cloudy)
- ☐ ☐ Blood in urine
- ☐ ☐ Discharge of mucous
- ☐ ☐ Kidney stones
- ☐ ☐ Kidney disorders
- ☐ ☐ Erectile dysfunction
- ☐ ☐ Prostate problems

Miscellaneous

- ☐ ☐ General fatigue / poor energy
- ☐ ☐ Weight loss / gain
- ☐ ☐ Fever / chills
- ☐ ☐ Cancer / tumors
- ☐ ☐ Lymph node removal
- ☐ ☐ Thyroid issues
- ☐ ☐ Systemic Lupus
- ☐ ☐ HIV/AIDS
- ☐ ☐ Low sexual function
- ☐ Born prematurely
  # of siblings _____

List scars, tattoos, piercings and mole removals:

_____

_____

For Women:

Any chance of being pregnant now? Yes / No

# of pregnancies ____ Miscarriages ____ Abortions ____

Menstruation: Regular __ Irregular __ Age at onset ___

Birth Control Pills Yes / No Infertility Yes / No

IUD Yes / No Other birth control _____

Period comes every ____ days and lasts ____ days

Cramps Yes / No Describe _____

_____

PMS Yes / No Describe _____

_____

Vaginal Discomfort/Discharge _____

Fibroids _____ Endometriosis _____ PCOS _____

Menopause:

When _____ Hormone Replacement Therapy _____

Do you have associated discomfort at present? Yes / No

Hysterectomy Yes / No Date and Reason _____

_____