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Welcome to my acupuncture & Chinese herbal medicine clinic! Please take the time to fill out this form to allow me to provide you with a more complete evaluation.

All of your answers will remain confidential. If you have any questions, feel free to ask me at any time. If there is anything you want to bring to my attention that is not listed on this form, please note it in the Comments section on the last page.

HEALTH HISTORY QUESTIONNAIRE (FOR INITIAL CONSULTATION)

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home tel: _____ Work: _____ Cell: _____

Email: _____ Date of birth: _____ Age: _____

Place of birth: _____ Height: _____ Weight: _____

Occupation: _____ Referred by: _____

In case of emergency, notify: _____ Tel: _____

Insurance carrier: _____ Policy no: _____

Have you ever been treated by acupuncture before? Yes No

Main issue(s) you would like help with: _____

How long ago did this problem begin? _____

To what extent does this issue interfere with your daily activities (work, sleep, eating, etc.)? _____

Have you been given a diagnosis? If yes, what was the diagnosis? _____

What kind(s) of treatment or therapy have you tried? _____

Past medical history (for you only, please mark the box & include dates):

Cancer	Diabetes	Hepatitis	High Blood Pressure	Heart Disease
Stroke	Seizures	Rheumatic Fever	Asthma	Thyroid Disease

Other significant illness (please describe): _____

Birth trauma (prolonged labor, forceps delivery, etc.): _____

Significant dental work (type and date): _____

Allergies (drugs, chemicals, foods, symptoms): _____

List any medications taken within the last two months (prescriptions, herbs, vitamins, etc.): _____

Describe other relevant medical history: _____

Family medical history (check the box):

Cancer	Diabetes	Hepatitis	High Blood Pressure	Heart Disease
Stroke	Seizures	Rheumatic Fever	Asthma	Thyroid Disease

Other relevant family medical history: _____

Occupational stress factors (list physical, chemical, and/or psychological factors): _____

Lifestyle factors: Do you have a regular exercise program? Yes No

Please describe: _____

Please describe your average daily diet:

Breakfast: _____ Lunch: _____ Dinner: _____

Have you ever been on a restricted diet? Yes No

If yes, what kind? _____

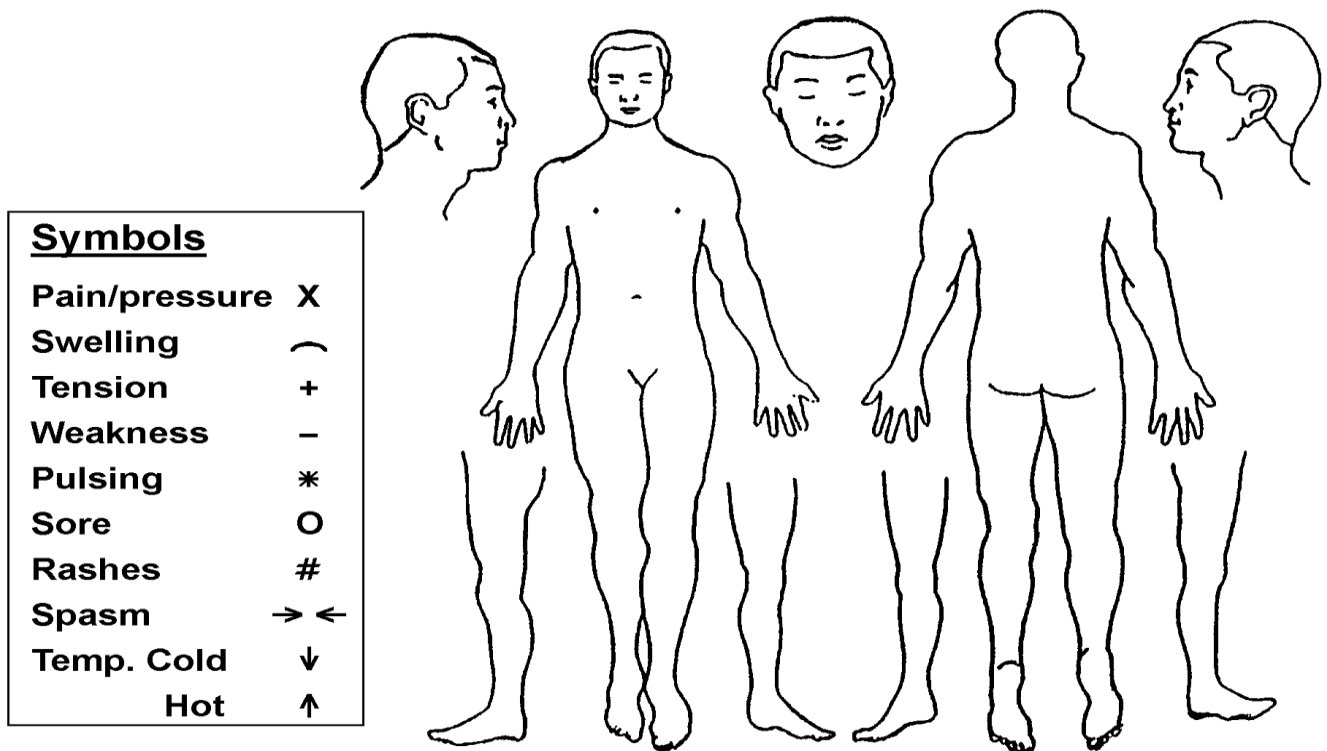
How much coffee, tea, or cola do you drink per week? _____

Do you smoke cigarettes? Yes No If yes, how many per day: _____

Do you drink alcohol? Yes No If so, how many drinks per week _____

Please describe any use of drugs for non-medical purposes: _____

Please indicate painful or distressed areas:



Indicate the degree of severity of your problem now (by marking the line):

| No problem _____ Worst imaginable |

Indicate your average energy level the past few weeks (by marking the line):

| Lack desire to move _____ Unlimited energy all day long |

Please check any symptoms you have now or have had in the past year:

HEAD <input type="checkbox"/> DIZZINESS <input type="checkbox"/> HEADACHES <input type="checkbox"/> MIGRAINES <input type="checkbox"/> FAINTING <input type="checkbox"/> LOSS OF BALANCE <input type="checkbox"/> HAIR LOSS	EARS <input type="checkbox"/> POOR HEARING <input type="checkbox"/> RINGING <input type="checkbox"/> EARACHES <input type="checkbox"/> DISCHARGE <input type="checkbox"/> BLEEDING	NECK <input type="checkbox"/> LUMPS <input type="checkbox"/> PAIN <input type="checkbox"/> RASHES <input type="checkbox"/> STIFFNESS <input type="checkbox"/> SWOLLEN GLANDS	BREAST <input type="checkbox"/> LUMPS <input type="checkbox"/> NIPPLE DISCHARGE <input type="checkbox"/> REDNESS <input type="checkbox"/> SWELLING <input type="checkbox"/> TENDERNESS/PAIN
EYES <input type="checkbox"/> LOSS OF VISION <input type="checkbox"/> BLURRY VISION <input type="checkbox"/> REDNESS <input type="checkbox"/> BURNING <input type="checkbox"/> DRYNESS <input type="checkbox"/> ITCHING <input type="checkbox"/> TICK/TWITCH <input type="checkbox"/> MUCOUS <input type="checkbox"/> PAIN	NOSE <input type="checkbox"/> BLEEDING <input type="checkbox"/> CLOGGED <input type="checkbox"/> DISCHARGE <input type="checkbox"/> LOSS OF SMELL <input type="checkbox"/> PAIN <input type="checkbox"/> POST-NASAL DRIP	MOUTH <input type="checkbox"/> BAD BREATH <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> DRY/CRACKING LIPS <input type="checkbox"/> EXCESSIVE THIRST <input type="checkbox"/> LOSS OF TASTE <input type="checkbox"/> BITTER TASTE <input type="checkbox"/> SORES <input type="checkbox"/> TOOTH PAIN <input type="checkbox"/> TEETH GRINDING	MUSCLE/JOINT/NERVES <input type="checkbox"/> BROKEN BONES <input type="checkbox"/> DIFFICULTY WALKING <input type="checkbox"/> MUSCLE WEAKNESS <input type="checkbox"/> STIFFNESS <input type="checkbox"/> TREMORS/TICKS <input type="checkbox"/> NECK PAIN <input type="checkbox"/> BACK PAIN <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> MUSCLE PAIN
DIGESTION <input type="checkbox"/> BLOATING <input type="checkbox"/> BLOODY STOOL <input type="checkbox"/> CONSTIPAITON <input type="checkbox"/> DIARRHEA <input type="checkbox"/> GAS <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> PAIN <input type="checkbox"/> BELCHING <input type="checkbox"/> REGURGITATION <input type="checkbox"/> VOMITING	URINATION <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> DIFFICULTY <input type="checkbox"/> DISCHARGE <input type="checkbox"/> EXCESSIVE <input type="checkbox"/> FREQUENT <input type="checkbox"/> SCANTY <input type="checkbox"/> PAINFUL	CIRCULATORY <input type="checkbox"/> CALF PAIN <input type="checkbox"/> COLD FEET <input type="checkbox"/> COLD HANDS <input type="checkbox"/> PUFFY EYES <input type="checkbox"/> SWOLLEN ANKLES <input type="checkbox"/> VARICOSE VEINS <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> HYPOTENSION <input type="checkbox"/> DIZZINESS <input type="checkbox"/> NUMBNESS	NEUROPSYCHOLOGICAL <input type="checkbox"/> SEIZURES <input type="checkbox"/> BAD TEMPER <input type="checkbox"/> LACK OF COORDINATION <input type="checkbox"/> DEPRESSION <input type="checkbox"/> EASILY SUSCEPTIBLE TO STRESS <input type="checkbox"/> POOR MEMORY <input type="checkbox"/> ANXIETY <input type="checkbox"/> OTHER_____
SKIN <input type="checkbox"/> ACNE <input type="checkbox"/> CHANGING MOLES <input type="checkbox"/> DRY/FLAKY <input type="checkbox"/> INSECT BITES <input type="checkbox"/> RASHES <input type="checkbox"/> ITCHY	CHEST <input type="checkbox"/> COUGH <input type="checkbox"/> PAIN/TIGHT PRESSURE <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> SHORTNESS OF BREATH	GENERAL <input type="checkbox"/> POOR APPETITE <input type="checkbox"/> INSOMNIA <input type="checkbox"/> DISTURBED SLEEP <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> FEVERS <input type="checkbox"/> CHILLS <input type="checkbox"/> SWEAT EASILY <input type="checkbox"/> BLEED/BRUISE EASILY <input type="checkbox"/> STRONG THIRST <input type="checkbox"/> BODY TEMP: HOT OR COLD <input type="checkbox"/> THIRST, BUT NO DESIRE TO DRINK	<input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> SUDDEN ENERGY DROP <input type="checkbox"/> FATIGUE <input type="checkbox"/> CRAVINGS <input type="checkbox"/> CHANGE IN APPETITE <input type="checkbox"/> CHILLS <input type="checkbox"/> POOR SLEEP <input type="checkbox"/> OTHER: _____

Comments—is there anything else you want to share that was not addressed by this form? _____

WOMEN'S HEALTH HISTORY

GENERAL

Date of your last pap smear: _____

Have you ever had an abnormal pap smear: Yes No If yes, when? _____

Date of last mammogram: _____

Have you gone through menopause: Yes No If yes, when? _____

Are you currently pregnant: Yes No

No. of pregnancies: _____ No. of miscarriages: _____ No. of abortions: _____

Are you currently practicing birth control: Yes No

If so, what kind? _____

MENSTRUAL HISTORY

Age when you started your period: _____

Please list your menstrual cycle (from start to start): _____

Please list number of days of menstrual bleeding during your cycle: _____

Do you have an irregular menstrual cycle: Yes No

If yes, is the cycle too long, is it too short, or do you skip cycles?: _____

Is your menstrual flow: Light Medium Heavy

Do you have bleeding or spotting in between your periods: Yes No

Please describe: _____

Do you have menstrual cramping/pain: Yes No

Please describe: _____

Do you have heavy bleeding during your cycle: Yes No

Do you have clotting during your cycle: Yes No

Please explain when this occurs: _____

DOES THE FOLLOWING OCCUR BEFORE OR DURING YOUR PERIOD?:

Water Retention: Before During N/A

Food Cravings: Before During N/A

Low back Pain: Before During N/A

Night sweats: Before During N/A

Mood Changes: Before During N/A

Breast Tenderness: Before During N/A

Decreased or no Sex Drive: Before During N/A

Other: _____

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?:

Vaginal Discharge: Currently In the past Never

Fibroids: Currently In the past Never

Genital Sores: Currently In the past Never

Ovarian Cyst: Currently In the past Never

Hysterectomy: Currently In the past Never

Other: _____
