VIBRANT LIFE
ACUPUNCTURE & INTEGRATIVE MEDICINE

Patient Information

Patient Name: _____

Date of Birth: _____ **Age:** _____ **Gender/Sex:** _____

Single: _____ **Married:** _____ **Separated:** _____ **Divorced:** _____ **Widowed:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Occupation: _____ **Employer:** _____

Emergency Contact:

Name & Relation: _____ **Phone #:**_____

How did you hear about us?: _____

Would like to learn additional health tips and join our newsletter? ☐ Of course I would! ☐ Not interested
(Promise there is some good stuff in it!)

I understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment or coverage. I understand that any outstanding account balances will be sent to collections after 90 days if payment has not been remitted.
An Eastern Medicine Practitioner in the State of North Carolina is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition has been diagnosed by your doctor and is not an emergency situation we will be happy to do so, so long as the condition has been diagnosed by your doctor and is not an emergency situation. If I decide want to alter my pharmaceutical regime in any way the I must consult my doctor before doing so. I have read the above and I understand and accept these policies.

Date: _____

Patient Signature: _____

Health History Questionnaire

Major Complaint(s):

- _____
- _____
- _____
- _____

How do these conditions affect your daily activities? _____

Why do you want this to be better?_____

Primary Physician: _____

Other physicians/therapists: _____

We find that when your ***healthcare providers are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. Is it okay if we contact the above healthcare providers to update them on the treatments you are receiving here? ❑ **YES PLEASE** ❑ **NO THANKS**

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

Supplements (vitamins, herbs, minerals, etc.): _____

Health History Questionnaire

List all hospital stays, surgeries, or major illnesses that you have had since birth	Year Occurred

Test	Year	Test Results
☐ Physical	_____	_____
☐ Cholesterol	_____	_____
☐ Prostate	_____	_____
☐ Mammogram	_____	_____
☐ Pap Smear	_____	_____
☐ Blood	_____	_____
☐ HIV/STD	_____	_____

Please check if you have or had any of the following conditions

☐ Diabetes	☐ Syphilis	☐ Mumps	☐ Jaundice
☐ Heart Disease	☐ CVA (Stroke)	☐ Rheumatic Fever	☐ Hepatitis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Vein Condition
☐ Allergies	☐ Gonorrhea	☐ Bleeding Tendency	☐ Tuberculosis
☐ Meningitis	☐ Measles	☐ High Blood Pressure	☐ Chicken Pox
☐ Epilepsy	☐ HIV	☐ Nervous Disorder	☐ Polio
☐ Paralysis	☐ High Fever	☐ Mononucleosis	☐ Migraines
☐ Glaucoma	☐ Cancer	☐ Multiple Sclerosis	☐ Anxiety

Health History Questionnaire

Please check all the symptoms that you are currently experiencing or experienced in the last 6 months.

PAIN CONDITION QUESTIONS

What makes the pain better?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other: _____

What makes the pain worse?

- ☐ Soft pressure
- ☐ Hard pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Rest
- ☐ Other:_____

TOTAL BOXES CHECKED: _____

DESCRIBE YOUR PAIN

- ☐ Sharp
- ☐ Fixed
- ☐ Burning
- ☐ Moving
- ☐ Cramping
- ☐ Aching
- ☐ Dull
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Lung & Kidney Function

- ☐ Shortness of breath
- ☐ General weakness
- ☐ Daily chronic fatigue & malaise
- ☐ Low energy
- ☐ Difficulty keeping eyes open (daytime)
- ☐ Easily catch colds
- ☐ Feel worse after exercise

TOTAL BOXES CHECKED: _____

Heart Function

- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Poor Memory
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Trouble falling and/or staying asleep

TOTAL BOXES CHECKED: _____

SLEEP

Total hours of sleep per night ____
Restless sleep? _____
Feel hot during the night? ____
What time do you go to bed? _____
How many times do you wake up? _____
Do you feel refreshed when you wake up? _____

Health History Questionnaire

Spleen Function

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Dizziness upon standing
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Worry, Overthinking
- ☐ Cold hands, fingers, nose
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Prolapsed organs: _____
- ☐ Limbs feel weak or lacks strength
- ☐ Craves sugar

TOTAL BOXES CHECKED: _____

Small/Large Intestine Function

- ☐ Loose stools
- ☐ Constipated
- ☐ Incomplete stools
- ☐ Foul smelling
- ☐ Explosive evacuation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools
- ☐ Excessive wiping, messy

TOTAL BOXES CHECKED: _____

Lung Function

- ☐ Nasal discharge (color: _____)
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Allergies (type:_____)
- ☐ Alternation of chills/fever
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Sneezing
- ☐ Itchy eyes
- ☐ Overall achy feeling in body
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (packs per day: _____)
- ☐ Sadness
- ☐ Melancholy

TOTAL BOXES CHECKED: _____

Stomach Function

- ☐ Burning sensation after eating
- ☐ Large appetite
- ☐ Bad Breath
- ☐ Canker sores (mouth)
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Belching
- ☐ Hiccups
- ☐ Stomach pain
- ☐ Vomiting

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Dampness Trapped in the Body

- ☐ **Bodily sensation of heaviness**
- ☐ **Mental heaviness**
- ☐ **Mental sluggishness**
- ☐ **Mental fogginess**
- ☐ **Swollen hands**
- ☐ **Swollen feet**
- ☐ **Swollen joints**
- ☐ **Chest congestion**
- ☐ **Nausea**
- ☐ **Snoring**

TOTAL BOXES CHECKED: _____

Liver Function (Eyes)

- ☐ **Itchy**
- ☐ **Bloodshot**
- ☐ **Hot**
- ☐ **Dry**
- ☐ **Watery**
- ☐ **Gritty**
- ☐ **Blurry vision**
- ☐ **Decreased night vision**
- ☐ **Near sighted**
- ☐ **Far sighted**

TOTAL BOXES CHECKED: _____

Liver, Gall Bladder Function

- ☐ **Alternating diarrhea & constipation**
- ☐ **Pain under ribs**
- ☐ **Tight sensation in chest**
- ☐ **Sigh frequently**
- ☐ **Anger easily**
- ☐ **Depression**
- ☐ **Frustration**
- ☐ **Irritability**
- ☐ **Skin rashes**
- ☐ **Headache at the top of the head**
- ☐ **Headache at temples**
- ☐ **Premenstrual Symptoms**
- ☐ **Tingling sensation**
- ☐ **Numbness**
- ☐ **Muscle twitching**
- ☐ **Muscle cramping at night**
- ☐ **Muscle spasms**
- ☐ **Seizures, Convulsions**
- ☐ **Bitter taste upon waking**
- ☐ **Lump in the throat**
- ☐ **Neck tension**
- ☐ **Shoulder tension**
- ☐ **Limited range of motion in neck**
- ☐ **Limited range of motion in shoulder**
- ☐ **Alcohol consumption (per day: _____)**
- ☐ **Recreational drug use (which: _____)**
- ☐ **Nails pale, brittle, ridges**
- ☐ **Pale lips**
- ☐ **High-pitched ringing in ears**
- ☐ **Gallstones**
- ☐ **STD's (which: _____)**
- ☐ **Blush easily with emotions like anger/stress**

TOTAL BOXES CHECKED: _____

Health History Questionnaire

Kidney Function (Overall Temperature)

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes only
- ☐ Cold knees
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temp. sensation
- ☐ Cold body temp. sensation
- ☐ Afternoon flushes
- ☐ Heat in the hands, feet & chest
- ☐ Hearing loss or declining
- ☐ Tinnitus low pitch ringing
- ☐ Hot flashes any time of the day
- ☐ Thirsty (drink lots or sip small amounts)
- ☐ Perspire easily
- ☐ Lack of perspiration

TOTAL BOXES CHECKED: _____

Kidney & Urinary Bladder Function

- ☐ Frequent cavities, teeth problems
- ☐ Easily broken bones
- ☐ Sore knees
- ☐ Weak knees
- ☐ Cold sensation in knees
- ☐ Low back pain
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Low-pitched ringing in ears
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Lack of bladder control
- ☐ Wake during the night to urinate
- ☐ Fear
- ☐ Easily Startled

TOTAL BOXES CHECKED: _____

Urination (Bladder Function)

- ☐ Color: Pale ___ Dark Yellow ___
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Night time urination, ___ times per night
- ☐ Frequent like >10 times per day
- ☐ Burning sensation
- ☐ Painful
- ☐ Dribbling
- ☐ Difficult
- ☐ Urgent

TOTAL BOXES CHECKED: _____

Libido

- ☐ Low
- ☐ High

Health History Questionnaire

WOMEN ONLY

Do you have a regular menstrual cycle?:	☐ Yes	☐ No
Are you pregnant?:	☐ Yes	☐ No
Do you have bleeding between periods?	☐ Yes	☐ No
Do you have excessive vaginal discharge?	☐ Yes	☐ No

Menstrual Cycle Symptoms

- ☐ Nausea
- ☐ Vomiting
- ☐ Food cravings
- ☐ Water retention
- ☐ Breast swelling
- ☐ Breast tenderness
- ☐ Headaches
- ☐ Migraines
- ☐ Dull pain
- ☐ Sharp pain
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Other:_____

TOTAL BOXES CHECKED: _____

Number of children ____ Number of pregnancies _____ Age of first menses _____
Date of start of last menses _____ How many total cycle days per month? _____
Bleed for _____ days Pain during bleeding _____ Describe your flow _____

MEN ONLY

- ☐ Swollen testes
- ☐ Testicular pain
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Coldness or numbness external genitalia
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

Nutrition

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Type of Diet:_____

Current weight: _____ Height:_____