Marianne Volpe, MAOM, Licensed Acupuncturist

Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of you answers will be held absolutely confidential. If you have any questions, please ask. Thank you

Date:				Referred by:	
First Name:		Last Name:		Cell Phone:	Work Phone:
Height:	Height:	DOB:	Age:	Marital Status:	Occupation:

Street:	City:	State:	Zip:
Emergency Contact:	Phone #:	Primary Care MD:	
Email address:	Best form of contact:		

Have you been treated by Acupuncture or Chinese Medicine before?
What is the main problem that brought you here today?
How long ago did this problem begin? Please be specific
Have you been given a diagnosis for this problem? If yes, what was the diagnosis and when was it given?
To what extent does this problem interfere with your daily activities, such as work, sleep, sex, etc.?
What treatments have you tried?

Surgeries		
Year	Reason	Outcome
Other hospitalizations		
Year	Reason	Outcome

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Medication	Strength	Frequency Taken	Comments

HEALTH HABITS AND PERSONAL SAFETY						
Exercise	□ Sedentary (No exercise)					
	□ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Have you ever been on a restricted diet? If yes, what kind?					
	Please describe the average daily food intake:					
	Morning	Afternoon	Evening	Snacks:		
Water Intake	How much water do you drink each day?					
Caffeine	□ None	# of cups/cans per day:	□ Coffee	□ Tea	□ Cola	
Alcohol	Do you drink alcohol?				□ Yes	□ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				□ Yes	□ No
Tobacco	Do you use tobacco?				□ Yes	□ No
	□ Cigarettes – packs./day		□ Chew - #/day	□ Pipe - #/day	□ Cigars - #/day	

	□ # of years	□ Or year quit		
Sex	Are you sexually active?		□ Yes	□ No
	If yes, are you trying for a pregnancy?		□ Yes	□ No
	If not trying for a pregnancy list contraceptive or barrier method used:			
	Any discomfort or pain with intercourse?		□ Yes	□ No

FAMILY HEALTH HISTORY

Please note the relationship to you of any of the following illnesses that apply to your family history:

	Relationship		Relationship
Cancer		Chronic Lung Disease	
Tuberculosis		Drug or Alcohol Abuse	
Diabetes		Mental Illness	
Heart Disease		Leukemia	
High Blood Pressure		Migraine Headaches	
Low Blood Pressure		Obesity	
Stroke		Hypothyroid	
Epilepsy		Hyperthyroid	
Allergies		Ulcer	
Asthma		Depression/Anxiety	
Glaucoma		High Cholesterol	
Gout		Kidney Disease	

	Present Age or Age at Death	Health (Good, Fair or Poor) If Deceased, cause of death		Present Age or Age at Death	Health (Good, Fair or Poor) If Deceased, cause of death
Father:			Children:		
Mother:					
Siblings:					

Lifestyle Information
Occupational Stress (chemical, physical, psychological, etc.):
How does stress manifest for you (eg. insomnia, irritability, over-eating, etc.)?
Do you have a regular exercise program? If yes, please describe

WOMEN'S HEALTH

Age at onset of Menstruation: Date of last menstruation: Period every _____ days
Age of Menopause:

Irregular Periods? If yes, please describe

Emotional changes with cycle? If yes, please describe

Color & Quality of Blood: Light / Dark /Bright Red Thick / Thin /Pasty

Menstrual Pain: Sharp / Dull / Achy Beginning / Middle / End of flow

Menstrual Clots: Size: Color: Beginning / Middle / End of flow

Unusual Periods: Heavy / Light / Stop & Start Other:

Spotting or pain between periods? □ Yes □ No

Sores on genitals? □ Yes □ No

Vaginal Discharge? Clear/White/Yellow/Red Thin/Thick/Cheese-like Vaginal Itching?

Are you dealing with infertility issues at this time? □ Yes □ No

Have you tried Western Fertility treatments? □ Yes □ No

Number of pregnancies _____ Number of Premature births_____ Number of Miscarriages_____

Number of live births _____ Number Abortions_____

Date of Last Pap Smear: Date of last Mammogram:

Results: Results:
Breast Lumps?

Excessive bleeding or other issues with birth? If yes, please describe □ Yes □ No

MENS HEALTH		
□ Impotence	□ Prostatitis	□ Sores on genitals
□ Premature Ejaculation	□ Low Sperm Count	□ Spermatorrhea

Do you usually get up to urinate during the night? If yes, # of times _____	□ Yes	□ No
Do you feel pain or burning with urination?	□ Yes	□ No
Do you feel burning discharge from penis?	□ Yes	□ No
Any testicle pain or swelling?	□ Yes	□ No

OTHER PROBLEMS
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

General:

□ Fevers	□ Poor Sleeping	□ Night Sweats
□ Sweat Easily	□ Chills	□ Cravings
□ Bleed or Bruise easily	□ Fatigue	□ Change in appetite
□ Peculiar tastes or smells	□ Strong thirst:	□ Weight gain
□ Sudden energy drop	Hot/Cold/Room temperature	□ Weight loss

Skin and Hair:		
□ Rashes	□ Ulcerations	□ Hives
□ Itching	□ Eczema	□ Pimples
□ Dandruff	□ Loss of hair	□
Recent Moles:		
Change in hair or skin texture:		
Any other hair or skin problems?		
Head, Eyes, Ears, Nose and Throat:		
□ Dizziness	□ Glasses	□ Spots in front of eyes
□ Concussions	□ Cataracts	□
Dates:	Diagnosis date:	□ Poor hearing
□ Nose Bleeds	□ Poor vision	□ Ringing in ears:
□ Facial pain	□ Eye strain	High pitch/Low pitch
□ Sinus problems	□ Night blindness	□ Earaches
□ Jaw clicks	□ Blurry vision	□

□ Migraines	□ Eye pain	□ Recurrent sore throats
□ Grinding teeth	□ Color blindness	□ Sores on lips or tongue
Headaches:		
Teeth problems:		
Any other head or neck problems?		
Cardiovascular:		
□ High blood pressure	□ Swelling of hands	□ Chest pain
□ Low blood pressure	□ Swelling of feet	□ Difficulty in breathing
□ Irregular heartbeat	□ Cold hands and feet	□ Blood clots
□ Fainting	□ Phlebitis	□
Any other heart or blood vessel problems?		
Respiratory:		
□ Cough	□ Coughing blood	□ Asthma
□ Bronchitis	□ Pneumonia	□ Pain with a deep breath
Difficulty breathing when lying down?		
Production of phlegm? If yes, what color?		
Any other lung problems?		
Gastrointestinal:		
□ Nausea	□ Vomiting	□ Diarrhea
□ Constipation	□ Gas	□ Belching
□ Black stools	□ Blood in stools	□ Indigestion
□ Bad breath	□ Rectal pain	□ Hemorrhoids
□ Abdominal pain or cramps	□ Chronic laxative use	□ Poor appetite
Any other problems with your stomach or intestines?		

Genito-Urinary:		
□ Urgency to urinate	□ How many times per day do you urinate?	□ Pain w/urination
□ Unable to hold urine		□ Blood in urine
□ Decrease in urine flow	□ Do you wake to urinate? How often?	□ Kidney stones
□ Color to urine? White/Yellow/Clear/Cloudy		□ Sores on genitals: How often?

Any other problems with your genital or urinary system?		
Musculoskeletal:		
◻ Neck pain	◻ Muscle pain	◻ Knee pain
◻ Back pain	◻ Muscle weakness	◻ Foot/Ankle pain
◻ Hand/Wrist pain	◻ Shoulder pain	◻ Hip pain
Any other joint or bone problem?		
Neuropsychological:		
◻ Seizures	◻ Depression	◻ Lack of coordination
◻ Areas of numbness	◻ Easily angered	◻ Loss of balance
◻ Tremors	◻ Anxiety	◻ Poor memory
◻ Fearful	◻ Easily susceptible to stress	◻ Sadness
Have you ever been treated for emotional problems?		
Have you ever considered suicide?		
Have you ever attempted suicide?		
Any other neuropsychological problems?		

Is there anything else you would like to discuss?

- Have you had a fever in the last 24 hours of 100°F or above?
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath?
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?

I understand that, because acupuncture work involves touch and close physical proximity, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage and bodywork from this practitioner. Please be prepared to let us know at the beginning of your session what you would like to have addressed in your body work treatment.

I further acknowledge that I am voluntarily participating in the above referenced activities with the full knowledge and understanding that said activities are taking place during the COVID-19 pandemic. I understand that while Synergy Wellness Center LLC and its employees and contractors will abide by all local, state, and federal government laws and guidelines, as well as CDC guidelines, in an attempt to keep employees and patients safe, that I assume ALL risks associated with participation in said activities during said pandemic, including but not limited to: any illness and any adverse physical and/or psychological effects from the same and/or loss of any income or other monetary loss incurred as a result of the effects of said illness and/or costs incurred in the treatment of the same. I accept full and total responsibility for my own health and agree to release, hold harmless, and indemnify, to the extent permitted by the law, Synergy Wellness Center LLC, its employees and contractors from any liability for any illness, injury, loss or damages I many incur as a result of contracting COVID-19 as a result of engaging in said above referenced activities.

I have read, understand, and agree to the content of this Agreement and voluntarily agree to the terms and conditions stated above.

_____ _____

Signature (must be over age 18) PRINT NAME

_____ _____

Legal Guardian (for youth under age 18) Date