

Neil Weinberg

ORIENTAL MEDICINE

Date _____ Referred by _____

Name _____ Date of birth _____

Height _____ Weight _____ Occupation _____

Address _____

Email Address _____

Telephone: Home (_____) _____ Work (_____) _____

In emergency notify _____

Relationship _____ Telephone (_____) _____

Physician _____ Telephone (_____) _____

Chief complaint _____

When did this begin? _____

Please describe the condition in detail: _____

What helps it? _____

What makes it worse? _____

What other types of treatments have you tried? _____

Secondary Complaints _____

PERSONAL HEALTH HISTORY

Have you ever been hospitalized? _____ If yes, please describe: _____

Do you smoke? _____ If yes, how much: _____

Do you drink alcoholic beverages? _____ If yes, how much: _____

Do you drink coffee? _____ If yes, how much per week: _____

Do you take any drugs or medications? _____ Please list: _____

On a scale of 1-10, how is your energy level in general? _____

When is it at its peak? _____ When is it lowest? _____

How would you describe your general emotional state? _____

Please list all herbs, vitamins, and supplements you are taking, and known dosages: _____

Please describe your appetite, including any food cravings: _____

Do you prefer hot or cold drinks? _____ Describe your diet on a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Do you engage in any physical activities? _____ Describe type and frequency:

Have you ever had acupuncture? _____ If yes, describe the problem and result:

DISEASES

Please help me provide you with a complete evaluation by filling out the following questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything not asked in the questionnaire that you wish to bring to my attention, please note it in the final section. Thank you.

Please answer all that apply:

General

- Chills
- Fevers
- Frequently feel cold
- Frequently feel hot
- Sweat easily
- Night sweats
- Localized weakness
- Where: _____
- Bleed or bruise easily
- Peculiar tastes or smells
- Describe: _____

- Strong thirst
- Thirst, no desire to drink
- Chronic fatigue
- Sudden energy drop
- Time of day: _____
- Edema
- Where: _____
- Insomnia
- Tremors
- Food Cravings
- Describe: _____

- Change in appetite
- Poor appetite
- Weight gain
- Weight loss
- Frequent colds, coughs

Skin, Hair

- Rashes
- Itching
- Dry skin
- Eczema
- Hives
- Pimples
- Recent moles
- Change in skin or hair
- Loss of hair
- Dandruff
- Other skin or hair problems:

Head

- Dizziness
- Migraines
- Headaches
- When: _____
- Where: _____
- Concussions
- Facial pain
- Grinding teeth
- Teeth problems
- Jaw clicks
- Other head or neck problems: _____

Eyes, Ears, Nose, Throat

- Impaired vision
- Spots in front of eyes
- Night blindness
- Color blindness
- Cataracts
- Eye pain
- Eye dryness
- Excessive tearing
- Discharge from eyes
- Impaired hearing
- Ringing in ears
- Earaches
- Discharge from ears
- Nose bleeds
- Sinus congestion
- Nasal drainage
- Recurrent sore throats
- Hoarseness
- Sores on lips or tongue

Cardiovascular

- Heart disease
- High blood pressure
- Low blood pressure
- Chest discomfort/pain
- Heart palpitations
- Cold hands or feet
- Swelling of hands
- Swelling of feet
- Blood clots
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems: _____

Respiratory

- Cough
- Asthma/wheezing
- Pain with deep breath
- Difficulty breathing while lying down
- Production of phlegm
- What color? _____
- Coughing blood
- Pneumonia
- Bronchitis
- Other lung problems: _____

Gastrointestinal

- Bad breath
- Nausea
- Vomiting
- Belching
- Indigestion
- Ulcers
- Constant hunger
- Abdominal pain, cramps
- Frequency of bowel movements: _____
- Diarrhea
- Constipation
- Laxative use
- Blood in stools
- Rectal pain
- Hemorrhoids
- Hepatitis
- Other stomach or intestinal problems: _____

Genitourinary

- Pain on urination
- Urgency to urinate
- Frequent urination
- Night urination
- Blood in urine
- Dark urine
- Decrease in urine flow
- Unable to hold urine
- Dribbling
- Kidney Stones
- Change in sex drive

- Impotency
 - Sores on genitals
 - Other genital urinary system problems:
-

Pregnancy/Gynecology

- Number of pregnancies: _____

- Number of births: _____
- Premature births: _____
- Miscarriages: _____
- Abortions: _____
- Age at first menses: _____
- Onset date of last menses: _____
- Days in menstrual cycle: _____
- Usual character:
Heavy _____ *Light* _____
- Painful menses
- Irregular menses
- Clots
- Spotting or bleeding between menses
- Changes in body/psyche prior to menstruation
- Menopause
Age: _____ Years: _____
- Vaginal discharge
- Breast tenderness
- Nipple discharge
- Date of last Pap smear: _____

Musculoskeletal

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pain

- Hip pain
- Knee pain
- Foot/ankle pain
- Muscle pain
- Muscle weakness
- Muscle cramps
- Arthritis
- Osteoporosis

Neuropsychological

- Easily worried
- Easily Startled or frightened
- Seizures
- Areas of numbness
- Weakness
- Sleep difficulties
- Disturbing dreams
- Quick to anger
- Irritable
- Loss of control/ violence potential
- Mental confusion or disorientation
- Dizziness
- Lack of coordination
- Impaired balance
- Impaired walking
- Poor memory
- Depression
- Susceptible to stress
- Anxiety
- Substance abuse
- Other neurological or emotional problems:

Have you ever been treated for emotional problems?

Other Maladies

- Allergies
List: _____
- Cancer
- Diabetes
- Thyroid disease
- HIV / AIDS

Please note here any other problems you would like to discuss: _____
