South Jersey Holistic

Polina Karmazin MD, LLC

Holistic Pain Management and Integrative Medicine

Acupuncture Initial Health Questionnaire

Name_____ Date of Birth_____

Gender: □ female □ male □ transgender Height: _____ Weight: _____

Have you ever had acupuncture before? □ yes □ no

If yes, please indicate condition and practitioner: _____

Name of Primary Care Physician: _____Phone_____

CHIEF HEALTH CONCERN

Please describe the reason you are seeking acupuncture treatment: _____

_____

_____

_____

How long have you experienced this health concern? _____

Have you seen a physician for this concern? □ yes □ no

If yes, please indicate date of last visit and name of provider: _____

Have you sought other forms of treatment for this concern? □ yes □ no

If yes, please indicate forms of treatment: _____

Has anything helped you with this health concern? □ yes □ no

If yes, please indicate what has helped you: _____

Please indicate anything that you feel makes your current health concern worse: _____

_____

_____

CHECK ANY THAT APPLY:

I have a pacemaker □ I have a defibrillator □ I have a metal surgical implant □

I take Coumadin/Warfarin/daily aspirin □ I am allergic to latex □ I am or may be pregnant □

LIFESTYLE BEHAVIORS: Please check any/all that apply and explain where indicated.

Frequency of Exercise/Physical Activity:

□ Never □ Occasionally (less than once weekly) □ Regularly (2-5 days/weekly) □ Daily

Type of exercise/physical activity: _____

How long do you exercise during each session? _____

Dietary Habits:

Do you follow a particular meal plan? □ yes □ no

If yes, please indicate type: _____

Do you consider yourself to be a vegetarian? □ yes □ no

If yes, please indicate type and for how long: _____

Number of meals and snacks per day: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6+

Do you have any food cravings? □ yes □ no If yes, please list: _____

Do you use sugar substitutes? □ yes □ no If yes, please indicate type(s) and amount used daily: _____

□ NutraSweet □ Sweet 'n Low □ Splenda □ Stevia □ Truvia □ Agave

Sleep Habits:

Number of hours you sleep (on average) per night: □ 5 or less □ 6 □ 7-8 □ 9 □ 10+

Do you work shift work? □ yes □ no If yes, please indicate shifts and rotation schedule: _____

Stress Management:

Do you feel you are stressed? □ yes □ no

If yes, how does stress affect you? _____

_____

Do you have a stress management plan? □ yes □ no

If yes, please describe: _____

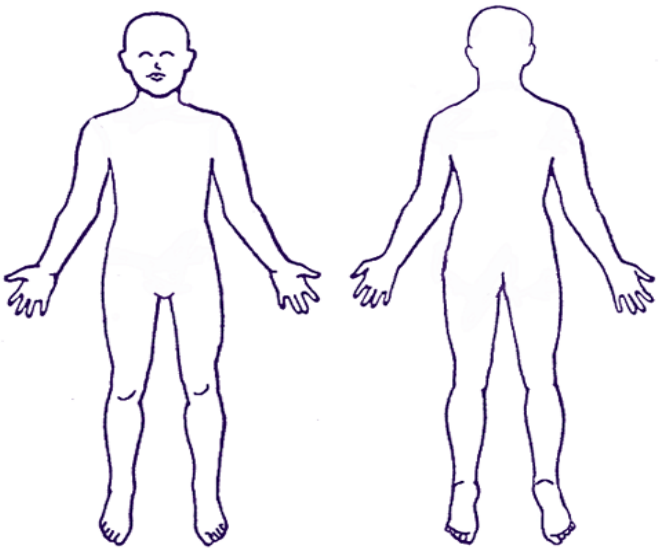
_____

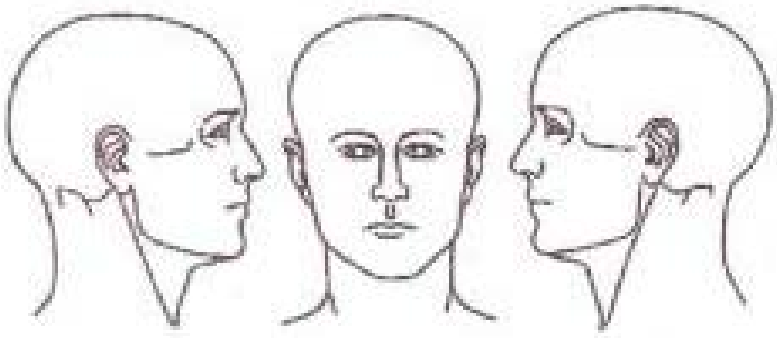
PERSONAL SATISFACTION

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Comments
Self	□	□	□	□	_____
Family	□	□	□	□	_____
Significant Other	□	□	□	□	_____
Overall Health	□	□	□	□	_____
Diet	□	□	□	□	_____
Work	□	□	□	□	_____
Exercise	□	□	□	□	_____
Spirituality	□	□	□	□	_____

PAIN ASSESSMENT: Place an "X" on any area where you experience pain.





HEALTH (Meridian Based) Survey

Please **circle** any symptoms that you have now. Please **underline** symptoms that have affected you in the past.

Hearing loss	Night time urination	Nightmares	Belching	Sore throat
Ringing in ears	Urinary problems	Muscle ache	Nausea	Recurrent bronchitis
Darkness under eyes	Low sex drive	Fatigue	Bloating	Asthma
Poor eyesight	Headaches	Joint pain	Hemorrhoids	Dry skin
Dry eye	Migraines	Cold hands and feet	Flatulence	Eczema
Dental problems	Tension in jaw	Excessive hunger	Loose stools	Shingles
Hair loss	Tense shoulder/neck	Gain weight easily	Diarrhea	Chemical sensitivity
Weak legs/knees	Jaundice	Poor appetite	Blood in stool	Food allergies
Lower back pain	Heart palpitations	Rapid weight loss	Light colored stool	Other:_____
Edema	Constipation	Worry	Easily catch colds	_____
Perspire easily	Indecisiveness	Rumination	Seasonal allergies	_____
Low Energy	Irritability	Gum disease	Chronic cough	_____
Dizziness	Anxiety	Halitosis	Shortness of breath	
Fearfulness	Memory problems	Cold/ mouth sores	Chronic Congestion	
Kidney stones	Insomnia	Heartburn	Sinus infections	

FOR WOMEN ONLY

Age at first menses: _____ Age at menopause: _____

Duration of menses: _____ Number of days between menses: _____

Please **circle** any/ all that applies now to your menstrual cycle, **underline** symptoms that have affected you in the past:

Painful periods	Irregular periods	Heavy periods	Light periods	Pelvic Inflammatory Disease
Fibrocystic Breast	Ovarian Cysts	Uterine Fibroids	Endometriosis	Infertility

FOR MEN ONLY

Date of last prostate check: _____ PSA results/date: _____

Please **circle** any symptoms that you have now. Please **underline** symptoms that have affected you in the past.

Frequent urination	Difficulty urinating	Painful urination	Dribbling urine
Urinary incontinence	Urinary retention	Rectal pain	Testicular pain
Increased libido	Decreased libido	Premature ejaculation	Impotence