Medica Vita. LLC

Welcome.

Please fill out the following information to the best of your ability. This is a CONFIDENTIAL questionnaire. Information provided contributes to determination of a successful treatment plan for you. We are glad to answer any questions. If you need assistance just ask.

Name: _____ Today's Date: ____/____/_____
(First Name) (Middle Name) (Last Name)

Home Address: _____ City: _____

State: _____ Zip: _____ E-Mail: _____

Phone Numbers: _____
Check Preferred: (Home) ☐ (Cell) ☐ (Office) ☐

Date of Birth: ____/____/_____ Age: ____ Gender: _____ Height: _____ Weight: _____

Emergency Contact: _____
(Name) (Phone)
In providing emergency contact information, you acknowledge that this person may be contacted in the event of a medical concern and information with respect to your health condition may be disclosed. Kindly indicate you're in agreement by writing your initials: _____

Who can we thank for referring you to this office: _____

Have you received acupuncture before? Yes ☐ No ☐ If yes, when? _____

For? _____ With whom? _____

List your main health concerns below, in order of importance: Number of months/years since onset:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Check the following that apply:

- ☐ I have a pacemaker
- ☐ I am taking Coumadin/Warfarin or similar blood thinning medication
- ☐ I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)
- ☐ I have known allergies to food and/or medications (please list below):

1. _____
2. _____
3. _____
4. _____
5. _____

Check if you have frequently taken:

____ Antibiotics
____ Antihistamines
____ Sedatives
____ Hormones
____ Birth Control Pills
____ Bronchial Inhalers
____ Cortisone
____ Nose Drops or Sprays
____ Skin Ointments
____ Vitamins
____ Anti-Depressants

Please list below, medications, vitamins, herbs and homeopathic remedies you currently take. You may use space at bottom of page if necessary:

Name **Dosage**

_____
_____
_____
_____
_____
_____
_____
_____

Do you have a personal or family history of:

Diabetes:	Self ☐	Family ☐	Hypertension:	Self ☐	Family ☐
Cardio-Vascular Disease:	Self ☐	Family ☐	Tuberculosis:	Self ☐	Family ☐
Allergies:	Self ☐	Family ☐	Rheumatic Fever:	Self ☐	Family ☐
Asthma:	Self ☐	Family ☐	Seizures:	Self ☐	Family ☐
Cancer:	Self ☐	Family ☐	Hepatitis:	Self ☐	Family ☐
Alcoholism	Self ☐	Family ☐	Thyroid Disorder	Self ☐	Family ☐

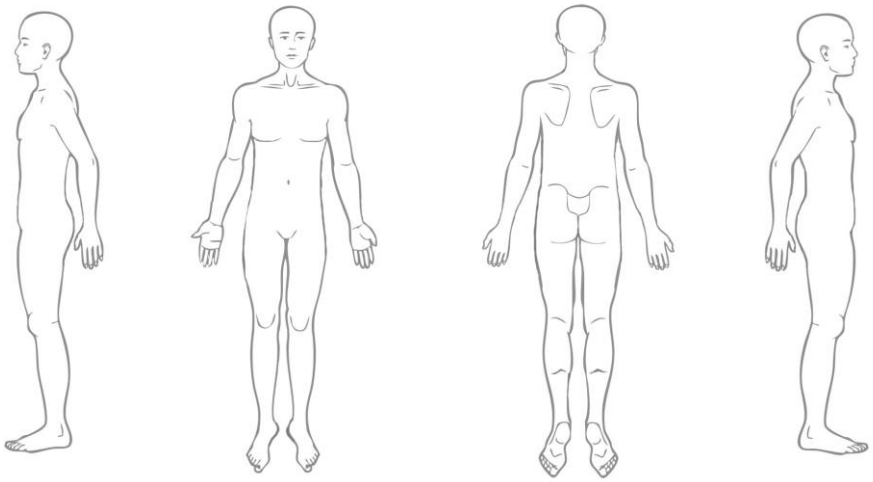
Have you ever been hospitalized for a:

Medical problem: No ☐ Yes ☐
Surgical procedure: No ☐ Yes ☐
Psychiatric reason: No ☐ Yes ☐

You may use this space to expand on any conditions that could be contributing factors to your current state of well-being. (Working long hours or night shifts, prolonged sitting, injuries or accidents, etc.)

_____
_____
_____
_____
_____
_____

Please indicate if there are certain physical areas you would like to concentrate on.



Lifestyle

Please indicate which of the following are a part of your lifestyle and how frequently do you engage in it: (Example: 2x/day, 5x/week, 3x/month, etc.)

Alcohol: Yes ☐ No ☐: ____drinks/wk
Exercise: Yes ☐ No ☐: _____times/wk
Coffee: Yes ☐ No ☐: _____cups/day
How many meals do you generally eat per day?____

Nicotine: Yes ☐ No ☐
Excessive Sugar Intake: Yes ☐ No ☐
Recreational Drug Use: Yes ☐ No ☐

Do you follow any particular diet? Yes ☐ No ☐ If yes, please describe:

_____

On the scale of 1-10, how would you rate your level of stress _____
How does stress affect you? (i.e., insomnia, tension headaches, digestive issues, etc.) Please describe briefly.

_____

Body Systems Review

Urination: Any urination issues? Yes ☐ No ☐
Burning ☐ Urgent ☐ Retention ☐ Scanty ☐ Profuse ☐ Dribbling ☐
Urination frequency greater than 1x per night Yes ☐ No ☐ If yes, frequency: ____ /night

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Bowel Movements: Any BM issues? Yes ☐ No ☐
Frequency: _____/day
Stools Contain: Undigested food ☐ Blood ☐ Mucus ☐
Consistency: Well-formed ☐ Hard ☐ Loose ☐ Alternates Hard/Loose ☐

Sleep:
Number of hours of sleep per night: _____ Is sleep restful? Yes ☐ No ☐

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

low appetite 0☐ 1☐ 2☐ 3☐ 4
☐ravenous appetite 0☐ 1☐ 2☐ 3☐ 4☐
thirst 0☐ 1☐ 2☐ 3☐ 4☐
loose stools 0☐ 1☐ 2☐ 3☐ 4☐
heartburn/acid reflux 0☐ 1☐ 2☐ 3☐ 4☐
mouth sores 0☐ 1☐ 2☐ 3☐ 4☐

fatigue after eating 0☐ 1☐ 2☐ 3☐ 4☐
gas/bloating after food 0☐ 1☐ 2☐ 3☐ 4☐
bruise easily 0☐ 1☐ 2☐ 3☐ 4☐
gums (bleeding/swollen) 0☐ 1☐ 2☐ 3☐ 4☐
organ prolapse (diagnosed) 0☐ 1☐ 2☐ 3☐ 4☐
belching or vomiting 0☐ 1☐ 2☐ 3☐ 4☐

fatigue 0☐ 1☐ 2☐ 3☐ 4☐
allergies 0☐ 1☐ 2☐ 3☐ 4☐
asthma 0☐ 1☐ 2☐ 3☐ 4☐
cough 0☐ 1☐ 2☐ 3☐ 4☐
nasal discharge 0☐ 1☐ 2☐ 3☐ 4☐
sinus congestion 0☐ 1☐ 2☐ 3☐ 4☐

catch colds easily 0☐ 1☐ 2☐ 3☐ 4☐
spontaneous sweat 0☐ 1☐ 2☐ 3☐ 4☐
shortness of breath 0☐ 1☐ 2☐ 3☐ 4☐
general weakness 0☐ 1☐ 2☐ 3☐ 4☐
dry nose/mouth/skin/throat 0☐ 1☐ 2☐ 3☐ 4☐
feel worse after exercise 0☐ 1☐ 2☐ 3☐ 4☐

feel cold 0☐ 1☐ 2☐ 3☐ 4☐
low back pain 0☐ 1☐ 2☐ 3☐ 4☐
ear problems 0☐ 1☐ 2☐ 3☐ 4☐
puffy eyes 0☐ 1☐ 2☐ 3☐ 4☐
edema 0☐ 1☐ 2☐ 3☐ 4☐

frequent urination 0☐ 1☐ 2☐ 3☐ 4☐
sore/cold/weak knee(s) 0☐ 1☐ 2☐ 3☐ 4☐
copious pale colored urine 0☐ 1☐ 2☐ 3☐ 4☐
urinary incontinence 0☐ 1☐ 2☐ 3☐ 4☐
early morning diarrhea 0☐ 1☐ 2☐ 3☐ 4☐

Impaired memory: yes ☐ no ☐
Infertility: yes ☐ no ☐

Hair loss: yes ☐ no ☐
Libido: high ☐ normal ☐ low ☐

Irritable 0☐ 1☐ 2☐ 3☐ 4☐
dry or red eyes 0☐ 1☐ 2☐ 3☐ 4☐
ear ringing (tinnitus) 0☐ 1☐ 2☐ 3☐ 4☐
numb extremities 0☐ 1☐ 2☐ 3☐ 4☐
tight feeling in chest 0☐ 1☐ 2☐ 3☐ 4☐
angers easily 0☐ 1☐ 2☐ 3☐ 4☐

bitter taste in mouth 0☐ 1☐ 2☐ 3☐ 4☐
neck/shoulder tension 0☐ 1☐ 2☐ 3☐ 4☐
muscle spasms/twitches 0☐ 1☐ 2☐ 3☐ 4☐
feel better after exercise 0☐ 1☐ 2☐ 3☐ 4☐
alternating diarrhea/constipation 0☐ 1☐ 2☐ 3☐ 4☐
symptoms worse with stress 0☐ 1☐ 2☐ 3☐ 4☐

anxiety 0☐ 1☐ 2☐ 3☐ 4☐
headaches 0☐ 1☐ 2☐ 3☐ 4☐
restlessness 0☐ 1☐ 2☐ 3☐ 4☐
feel heart beating 0☐ 1☐ 2☐ 3☐ 4☐
chest pain 0☐ 1☐ 2☐ 3☐ 4☐

insomnia 0☐ 1☐ 2☐ 3☐ 4☐
disturbing dreams 0☐ 1☐ 2☐ 3☐ 4
sores on tip of tongue 0☐ 1☐ 2☐ 3☐ 4☐
chest pain traveling to shoulder 0☐ 1☐ 2☐ 3☐ 4☐

Overall body temperature high ☐ normal ☐ low ☐ Overall energy level high ☐ normal ☐ low ☐

see floaters in the eye 0☐ 1☐ 2☐ 3☐ 4☐
afternoon fever 0☐ 1☐ 2☐ 3☐ 4☐
foggy thinking 0☐ 1☐ 2☐ 3☐ 4☐
night sweats 0☐ 1☐ 2☐ 3☐ 4☐
heat in palms or soles 0☐ 1☐ 2☐ 3☐ 4
☐enlarged lymph nodes 0☐ 1☐ 2☐ 3☐ 4☐

dizzy upon standing 0☐ 1☐ 2☐ 3☐ 4☐
painful urination 0☐ 1☐ 2☐ 3☐ 4☐
feeling of heaviness 0☐ 1☐ 2☐ 3☐ 4☐
face flushes 0☐ 1☐ 2☐ 3☐ 4☐
nausea 0☐ 1☐ 2☐ 3☐ 4☐
candida 0☐ 1☐ 2☐ 3☐ 4☐

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People with Male Anatomy:

Have you been diagnosed with prostate problems? Yes ☐ No ☐
Do you experience premature ejaculation? Yes ☐ No ☐
Do you have problems with impotence? Yes ☐ No ☐
Have you been diagnosed with infertility? Yes ☐ No ☐
Male Diseases/Disorders:

Then proceed to bottom of last page

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People with Female Anatomy:

Menopause: Have you experienced menopause? Yes ☐ No ☐ If Yes, when?____

Are you on HRT (hormone replacement therapy) or herbal aids now? Yes ☐ No ☐
If you are experiencing menopausal symptoms, please describe:

_____

** If you are post-menopausal, then complete the next section as it applies to you. It is helpful to know what your menstruation and gynecological history was like, prior to menopause.*

Fertility History

Are you pregnant now? Yes ☐ No ☐ ….*Maybe*? ☐
Have you ever been pregnant? Yes ☐ No ☐
Number of Live Births: _____ Miscarriages/Abortions: _____

Menstrual History

At what age did you get your first period? _____
When was the 1st day of your last menstrual cycle: (date) ____/_____/_____
Are you currently taking oral contraceptives (the pill?) Yes ☐ No ☐
Are you utilizing another medical birth control therapy? Yes ☐ No ☐ Type: _____
# of days from start of one period to the start of the next: _____

Are your menstrual cycles spaced regularly? Yes ☐ No ☐ Number of flow days: _____
Use of tampon or pad is:
- Light ☐ = use one for longer than 4 hours,
- Moderate ☐ = change every 2-3 hours,
- Heavy ☐ = change every hour or less,

On maximum flow day, blood color is: Pink ☐ Red ☐ Dark ☐ Bright Red ☐ Brown ☐ Other: _____
Are there clots present? Yes ☐ No ☐
Does your period cause pain or cramping? Yes ☐ No ☐
If yes: Before ☐ During ☐ After Period ☐
Nausea or vomiting with your period? Yes ☐ No ☐

If yes: Before ☐ During ☐ After Period ☐

Do you experience any of the following before your period each month?

☐Water Retention ☐Breast Tenderness/Swelling

☐Mental Depression ☐Irritability ☐Food Cravings ☐Migraines ☐Other: _____

Do you ever bleed or spot between periods? Yes ☐ No ☐

Do you have any *atypical* vaginal discharge between periods? Yes ☐ No ☐

(some vaginal discharge that is painless, ranges from clear to pale yellow is normal)

Gynecological Background

Approximate date of last pap smear _____ Ever had an abnormal pap smear? Yes ☐ No ☐

Any gynecological surgery? Yes ☐ No ☐ _____

Have you ever had venereal disease or PID? Yes ☐ No ☐ If yes, when? (approx. date) ___/___/___

Do you get yeast infections regularly? Yes ☐ No ☐

Have you ever been diagnosed with:

Uterine fibroids or polyps ☐ Ovarian cysts ☐ PCOS ☐

Endometriosis ☐ Pelvic adhesion abnormalities ☐ Other ☐ **

**If other please describe

_____

Infertility work up (if pertinent)

Doctor or clinic: _____ When? _____

Do we have your permission to correspond with your reproductive specialist? Yes ☐ No ☐What tests have been conducted (HSG, hormone levels, blood work)? What were the findings?

Current fertility medications (Clomid, Lupron, Menopur, Gonal F, Ovidrel, HCG, Progesterone, etc.) and treatment plan:

_____

_____

I have provided correct and complete information to the best of my knowledge.

_____	_____/_____/_____
Patient's Signature	Date