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Date _____

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential, unless you sign a waiver allowing your records to be released. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the Comments Section on page 4.

Name:		Work Phone:		Home Phone:		Mobile Phone	
Address:		City:	State:	Zip Code:	EMAIL:		In Emergency, Contact
							Name: Phone:
Sex:	Age:	Date of Birth:	Place of Birth:		Height:	Weight:	
<input type="checkbox"/> Female <input type="checkbox"/> Male							
Employer Name:		Occupation:	Family Physician:		Referred By:		
Marital Status (check one):			Have you been treated by acupuncture or oriental medicine before				
<input type="checkbox"/> Never Married <input type="checkbox"/> Living with Partner <input type="checkbox"/> Married		<input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Health Concerns							
1) What is/are your main health concerns:							
2) How long ago did this problem begin?							
3) Was there a known cause/instigating factor?							
4) To what extent does this problem interfere with your daily activities?							
5) Have you been given a medical diagnosis for this problem? If so, what?							
6) What kinds of treatment have you tried?							
Past Medical History (please include date):							
<input type="checkbox"/> Cancer _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> High Blood Pressure _____		<input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Rheumatic Fever _____ <input type="checkbox"/> Thyroid Disease _____ <input type="checkbox"/> Seizures _____ <input type="checkbox"/> HIV _____			<input type="checkbox"/> STDs _____ <input type="checkbox"/> Other: _____		

Surgeries (type of and date):

Significant Trauma (auto accidents, falls etc.):

Allergies (drugs, chemicals, foods/result):

Family Medical History (check):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Allergies
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other:
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Heart Disease		

Medicines/supplements taken within the last month (vitamins, drugs, herbs, etc.):

1) Current medications (names & dosages):

2) Vitamins/supplements/herbs:

3) Do you have a regular exercise program? Please describe:

Please Describe Your Average Daily Diet:

Morning:

Afternoon:

Evening:

1) How many packs of cigarettes do you smoke per day?

2) How much coffee, tea or cola do you drink per week? Alcohol?

3) Rate your stress levels on a scale of 1-10 during an average week:

4) Please describe any use of drugs for non-medical purposes:

DIRECTIONS : Please Check The Appropriate Box For Any Symptoms You Have Had in the Last Few Months.

Mild/Infrequent ① ② ③ Severe/Frequent

GENERAL

<input type="checkbox"/> ① ② ③ Chills	<input type="checkbox"/> ① ② ③ Poor sleeping	<input type="checkbox"/> ① ② ③ Lack of coordination
<input type="checkbox"/> ① ② ③ Sweat easily	<input type="checkbox"/> ① ② ③ Poor appetite	<input type="checkbox"/> ① ② ③ Loss of balance
<input type="checkbox"/> ① ② ③ Night sweats	<input type="checkbox"/> ① ② ③ Weight gain	<input type="checkbox"/> ① ② ③ Vertigo/dizziness
<input type="checkbox"/> ① ② ③ Bleed or bruise easily	<input type="checkbox"/> ① ② ③ Weight loss	<input type="checkbox"/> ① ② ③ Areas of numbness
<input type="checkbox"/> ① ② ③ Strong thirst (hot or cold drinks)	<input type="checkbox"/> ① ② ③ Dental/gum problems	<input type="checkbox"/> ① ② ③ Poor memory
<input type="checkbox"/> ① ② ③ Fatigue	<input type="checkbox"/> ① ② ③ Seizures	

SKIN and HAIR

<input type="checkbox"/> ① ② ③ Itching	<input type="checkbox"/> ① ② ③ Recent moles	<input type="checkbox"/> ① ② ③ Loss of hair/thinning
<input type="checkbox"/> ① ② ③ Eczema	<input type="checkbox"/> ① ② ③ Loss of hair/thinning	<input type="checkbox"/> ① ② ③ Dandruff
<input type="checkbox"/> ① ② ③ Hives	<input type="checkbox"/> ① ② ③ Dandruff	
<input type="checkbox"/> ① ② ③ Acne		

Other hair or skin problems:

HEAD, EYES, EARS, NOSE and THROAT

<input type="checkbox"/> ① ② ③ Dizziness	<input type="checkbox"/> ① ② ③ Spots in front of eyes	<input type="checkbox"/> ① ② ③ Nose bleeds
<input type="checkbox"/> ① ② ③ Migraines	<input type="checkbox"/> ① ② ③ Eye pain	<input type="checkbox"/> ① ② ③ Sinus congestion

① ② ③ Headaches ① ② ③ Poor vision ① ② ③ Blurry vision ① ② ③ Night blindness	① ② ③ Cataracts ① ② ③ Hearing loss ① ② ③ Ringing in ears ① ② ③ Earaches	① ② ③ Grinding teeth ① ② ③ Recurrent sore throats/colds ① ② ③ Concussion
Other head or neck problems:		
CARDIOVASCULAR		
① ② ③ High blood pressure ① ② ③ Low blood pressure ① ② ③ Chest discomfort/pain ① ② ③ Heart palpitations	① ② ③ Cold hands or feet ① ② ③ Swelling of hands or feet ① ② ③ Blood clots	① ② ③ Fainting ① ② ③ Difficulty in breathing ① ② ③ Varicose/spider veins
Other heart or blood vessel problems:		
RESPIRATORY		
① ② ③ Production of phlegm? **What color: _____	① ② ③ Cough ① ② ③ Asthma/wheezing ① ② ③ Pneumonia ① ② ③ Bronchitis	Other respiratory problems:
GASTROINTESTINAL		
① ② ③ Bad breath ① ② ③ Nausea ① ② ③ Vomiting ① ② ③ Belching ① ② ③ Bloating	① ② ③ Acid reflux/GERD ① ② ③ Diarrhea/Loose stools ① ② ③ Constipation ① ② ③ Abdominal pain/cramps	① ② ③ Intestinal gas ① ② ③ Rectal pain ① ② ③ Hemorrhoids ① ② ③ History of gallbladder attacks or stones
Other stomach or intestinal problems:		
GENITO-URINARY		
① ② ③ Pain on urination ① ② ③ Urgency to urinate ① ② ③ Frequent urination ① ② ③ Blood in urine ① ② ③ Burning urination ① ② ③ Urinary tract infection ① ② ③ Prostatitis ① ② ③ Decrease in flow	① ② ③ Unable to hold urine ① ② ③ Dribbling ① ② ③ Kidney stones ① ② ③ Pain in testicles ① ② ③ Impotency ① ② ③ Change in sexual drive	① ② ③ Decreased libido ① ② ③ Excessive libido ① ② ③ Genital sores ① ② ③ Herpes Do you wake up to urinate? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? : _____
Other genital or urinary system problems:		
GYNECOLOGY/REPRODUCTIVE		
____ Number of pregnancies ____ Number of births ____ Number of ectopic pregnancies ____ Number of Miscarriages ____ Number of Abortions ____ Age of first menses ____ Period between menses Duration _____ Date of last menses _____ Menstrual flow: <input type="checkbox"/> heavy <input type="checkbox"/> light <input type="checkbox"/> moderate ① ② ③ Increased vaginal pain, dryness or itching	① ② ③ Painful periods ① ② ③ Irregular periods ① ② ③ Clots ① ② ③ PMS ① ② ③ Nipple discharge ① ② ③ Breast lumps ____ Menopause: **Age: _____ **Year: _____ ① ② ③ Hot flashes ① ② ③ Unusual vaginal discharge	① ② ③ Vaginal sores ① ② ③ Painful intercourse ① ② ③ Infertility ① ② ③ Ovarian cysts ① ② ③ Endometriosis ① ② ③ Uterine fibroids ① ② ③ Polycystic Ovarian Disease ① ② ③ Facial hair growth Date of last Pap/pelvic? Do you practice birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No What type and for how long?
Other GYN problems:		

MUSCULOSKELETAL

① ② ③ Neck pain	① ② ③ Hand/wrist/arm pain	① ② ③ Foot/ankle pains
① ② ③ Shoulder pain	① ② ③ Hip pain	① ② ③ Muscle pains
① ② ③ Back pain	① ② ③ Knee pain	① ② ③ Muscle weakness
① ② ③ Sciatica		

Other Musculoskeletal problems:

PSYCHOLOGICAL

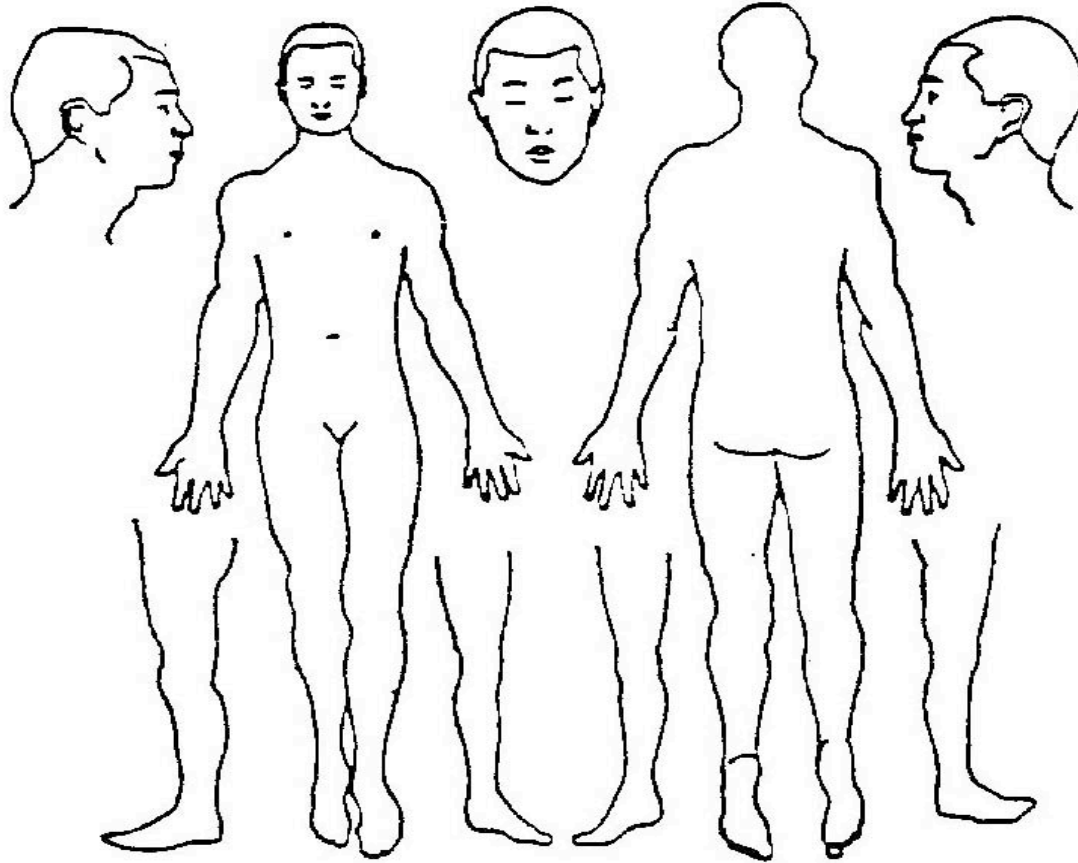
① ② ③ Irritable	① ② ③ Easily susceptible to stress	① ② ③ Anxiety
① ② ③ Depression		① ② ③ ADD/ADHD
① ② ③ Manic depression		① ② ③ Seasonal affective disorder

Other Psychological problems:

Other neurological or psychological problems:

- 1) Have you ever been treated for emotional problems?
 Yes No
- 2) Have you ever considered or attempted suicide?
 Yes No
- 3) Have you ever been treated for substance abuse?
 Yes No

Indicate painful or distressed areas:



Comments (any other problems you would like to discuss):

Empty rectangular box for providing additional comments or details.