PATIENT DATA:

Date:___________________

Name:____

Address:____

City/State/Zip:____

Phone: (h)______________________________ (w)___________________________ (cell) ________________________

Date of Birth:______________ Age: _________ Email: ____

Circle One: single partnered married separated divorced widowed Gender: _______________

Occupation: _________________________Name of Spouse/Partner or Parent (if child) __________________________

Emergency contact: (name) ____ (phone) __________________________

How did you learn about our office? ____

Current Physician ___________________________________Diagnosis by MD__________________________________

Which of the following have you experienced before? **Circle all that apply:** Acupuncture Herbal Medicine

Chiropractic Massage Hypnosis Emotional Freedom Techniques Dietary Consultation

PRIMARY COMPLAINTS:

1.
2.
3.

MEDICAL HISTORY:

MEDICATIONS: Please list all prescribed (allopathic) drugs, non-prescribed medications, vitamins, herbs etc., you are taking, stating what they are used for.

1.
2.
3.
4.

Please check: Do you use or do any of the following on a regular basis?

Alcohol	Tobacco	Drugs	Coffee or Tea	Exercise	Soft drinks	Sugar	Soy Products	Wheat/ Gluten	Vegetarian diet

Please list any hospitalizations, accidents, and past illnesses. Include dates and ages.

1.
2.
3.
4.

Please list any serious diseases in your family history such as Cancer, Diabetes, Hypertension, Heart disease etc.

Mother: Father:

Grandparents: Siblings:

Please check current complaints

Musculoskeletal

Neck Pain	Hip Pain	Leg Cramps
Back Pain	Knee Pain	Muscle Atrophy
Hand/Wrist Pain	Foot/Ankle Pains	Muscle Pains
Elbow Pain	Hernia Pain	Muscle Spasms
Arm Pain	Deformities of Bones	Muscle Weakness
Shoulder Pain	Brittle Bones	Areas of Numbness & Tingling
Rib Pain	Joint Swelling	Other:

Neurophysiological/ Emotional

Seizures	Convulsions	Poor Memory/Concentration
Regions of Numbness	Dizziness	Anxiety
Head Injury	Lack of Coordination / Balance	Sadness
Bad Temper	Low Stress Tolerance	Weepy
Worry, Over-thinking	Fearful	Depression
Mood Swings	Suicidal	Paralysis
Confusion	Tremors / Tics	Mental Illness

General

Night Sweats	Sleep Too Much	Rashes
Fevers / Chills	Insomnia	Fungal Infections
Hot or Cold Intolerance	Nightmares	Psoriasis
Spontaneous Sweating	Bleed or Bruise Easily	Eczema
Weakness	Swollen Glands	Itchy or Dry Skin
Fatigue	Cravings	Acne
Sudden Energy Drop: time?	Weight Gain/Loss	Ulcerations
Auto-Immune disease	Dental amalgam fillings	Infections e.g. HIV+, Lyme, EBV
Immune issues like high ANA titer	Hair loss	Premature birth
Forceps delivery	Held in an incubator	Life threatening event

Cardiovascular

High Blood Pressure	Irregular Heartbeat	Swelling of Feet/Hands
Low Blood Pressure	Rapid Heartbeat / Palpitations	Blood Clots
Chest Pain	Fainting	Varicose Veins

Respiratory

Asthma	Bronchitis	Sinus Congestion
Allergies	Pneumonia	Production of Phlegm: Color?
Cough	Difficulty Breathing	Nose Bleeds
Coughing Blood	Catch Colds Frequently/Easily	Other:

Gastrointestinal

Increased Appetite	Bad Breath	Mouth Sores
Decreased Appetite	Belching	Excessive Thirst
Nausea	Hiccups	Problems Swallowing
Vomiting	Gas	Heartburn / Reflux / Indigestion

Food Sits in Stomach	Hiatal Hernia	Parasites
Peculiar Tastes / Smells	Constipation	Itchy Anus
Gallstones	Diarrhea	Food Allergies
Hepatitis	Loose Stools	Desire for Hot / Cold Foods
Hemorrhoids	Anal Fissures	Dark / Light / Bloody stools
Current Weight______lbs	Rectal Pain	Other GI issue:

Genito-Urinary

Painful / Difficult Urination	Decrease in Flow	Urinary Tract Infection
Urgency to Urinate	Dark / Odorous Urine	Interstitial Cystitis
Frequent Urination	Unable to Hold Urine	Kidney Stones
Blood in Urine	Bedwetting	Genital Sores
Cloudy Urine	Night time Urination	Edema: where? ___________

Head, Eyes, Ears & Throat

Headaches	Light Sensitivity	Earaches
Migraines	Red / Itchy Eyes	Ringing in Ears
Fainting	Poor Night Vision	Dizziness
Pressure in Eyes / Ears	Spots in Front of Eyes / Floaters	Sores on Lips / Tongue
Eye Pain	Poor Hearing	Grinding Teeth

Women

Cycle Length: ____ days	Vaginal Dryness	Increased / Decreased Libido
Days of bleeding: ____ days	Endometriosis	Hot Flashes
Heavy or Light Periods	Method of Birth Control?	Night Sweats
Menstrual Blood Color: ___________	Number of Pregnancies _____	Sexually Transmitted Disease
Menstrual Pain	Number of Children _____	HPV positive? Yes No
Clots	Number of Abortions ______	Vaginal Discharge/ Sores
PMS	Difficult Birth / Caesareans	Breast Problems
Polycystic Ovarian Disease (PCOS)	Are you pregnant? Yes No	Age Menses began ______
Irregular or No Periods	Date of last PAP? _________	Age at Menopause _______
Female Fertility issues	Infertility	Number of Miscarriages _____
Anovulation	Luteal Phase Problems	Pelvic Inflammatory Disease
Used birth control pills or Depo-Provera	Tested positive for Chlamydia? Yes No	# of IUI or IVF cycles? ______
FSH level ______ AMH level _______	Fibroids Adhesions Cysts	Low Progesterone

Males

Prostate Problems	Painful / Swollen Testicles	Discharge
Erectile Dysfunction	Increased / Decreased Libido	Sexually Transmitted Disease
Male Fertility issues	Infertility	Varicocele
Undescended testicles	Sperm Analysis normal? Yes No	Immune issues like Antisperm Antibodies

Anything else you would like us know: ____

**We work with chemically sensitive patients. Please refrain from using scented products on the day of your appointment.

Oriental Health Solutions, LLC, 907 Broad St., Durham, NC 27705 - **New Patient Questionnaire**

Health Questionnaire - Please circle appropriate number: 0=never/least, 1=occasionally, 2=frequent, 3=all the time

SECTION - A	0	1	2	3	How often do you feel you lack artistic appreciation?	0	1	2	3
Is your memory noticeably declining?	0	1	2	3	How often do you feel depressed in overcast weather?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3	How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3	How much are you losing enjoyment for your favorite foods?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3	How much are you losing enjoyment of friendships and relationships?	0	1	2	3
How often do you have a hard time remembering your appointments?	0	1	2	3	How often do you have difficulty falling into deep restful sleep?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3	How often do you have feelings of dependency on others?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3	How often do you feel more susceptible to pain?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3	How often do you have feelings of unprovoked anger?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3	How much are you losing interest in life?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3	**SECTION 2 - D**	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3	How often do you have feelings of hopelessness?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3	How often do you have self-destructive thoughts?	0	1	2	3
SECTION - B	0	1	2	3	How often do you have an inability to handle stress?	0	1	2	3
How high is your stress level?	0	1	2	3	How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3	How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3	How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3	How often do you have unexplained lack of concern for family and friends?	0	1	2	3
Do you find it difficult to get regular exercise?	0	1	2	3	How easily are you distracted from your tasks?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3	How often do you have an inability to finish tasks?	0	1	2	3
Do you feel you are not accomplishing your life's purpose?	0	1	2	3	How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3	How often do you feel your libido has been decreased?	0	1	2	3
SECTION C1	0	1	2	3	How often do you lose your temper for minor reasons?	0	1	2	3
How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3	How often do you have feelings of worthlessness?	0	1	2	3
How often do you feel energized after eating?	0	1	2	3	**SECTION 3 – G**	0	1	2	3
How often do you have difficulty eating large meals in the morning?	0	1	2	3	How often do you feel anxious of panic for no reason?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3	How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3	How often do you feel knots in your stomach?	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3	How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3	How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3	How often does your mind feel restless?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3	How difficult is it to turn you mind off when you want to relax?	0	1	2	3
SECTION - C2	0	1	2	3	How often do you have disorganized attention?	0	1	2	3
Do you get fatigued after meals?	0	1	2	3	How often do you worry about things you were not worried about before?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3	How often do you have feelings of inner tension and inner excitability?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3	**SECTION 4 - ACH**	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3	Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3	Do you feel your verbal memory is decreased?	0	1	2	3
Do you suffer from frequent urination?	0	1	2	3	Do you have memory lapses?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3	Has your creativity been decreased?	0	1	2	3
Do you experience weight gain when under stress?	0	1	2	3	Has your comprehension been diminished?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3	Do you have difficulty calculating numbers?	0	1	2	3
SECTION 1 – S	0	1	2	3	Do you have difficulty recognizing objects & faces?	0	1	2	3
Are you losing your pleasure in hobbies and interests?	0	1	2	3	Do you feel like your opinion about yourself has changed?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3	Are you experiencing excessive urination?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3	Are you experiencing slower mental response?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3					
How often do you feel sad or down for no reason?	0	1	2	3					
How often do you feel like you are **not** enjoying life?	0	1	2	3	All Rights Reserved © 2009 Datis Kharrazian				

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