Julianne Ambrosia, L.Ac, Dipl. OM
Intake and Health History

This is a CONFIDENTIAL questionnaire. This will help me determine the best course of treatment. If you have any questions please ask.

Name:_____

Address:_____

City:_____Zip:_____

Phone Number:_____ Cell Number:_____

Email Address:_____

Occupation:_____ Work Number:_____

Emergency Contact:_____ Number:_____

Who may I thank for referring you to my office? _____

Sex: _____ Height: _____ Weight:_____ Birthday:_____ Age:____

Marital Status: _____ Number of Children: _____

Have you received acupuncture before: _____With whom?_____

Please list any medications, OTC medications, supplements, vitamins, or herbs you are currently taking:

Medication	Dosage	Reason	How Long

Please indicate any major illnesses/conditions you or a blood relative (parent, sibling, grandparent) have had:

Illness/Condition:	Who?	Date (approximate)
Cancer:		
Hepatitis:		
High Blood Pressure:		
Rheumatic Fever:		
Infectious Disease:		
Diabetes:		
Heart Disease:		
Seizures:		
Emotional Disorders:		
Tuberculosis:		
Gonorrhea:		
Syphilis:		
HIV:		
AIDS:		
HPV:		
Chlamydia:		
Herpes:		

Do you drink alcohol? _____If yes, how frequent? _____
Do you smoke?_____ If yes, how many per day? _____
Do you drink coffee? _____ If yes, how many cups per day? _____
Do you take recreational drugs? _____If yes, what and frequency?_____
Do you drink soda/pop? _____If yes, how often? _____
How often do you eat out? _____
How many 8oz glasses of water do you drink per day? _____
Do you prefer your water hot, cold, or room temperature? _____

What is your reason for seeking treatment? _____
_____
_____

What other treatment therapies have you sought for this? _____
_____
_____

Do you have a Latex allergy? _____
Do you have any allergies to medications? _____
Do you have any food allergies or sensitivities? _____
_____

Please list any major illnesses, surgeries, accidents with dates. _____
_____
_____

Diet:

How many times a day do you eat? _____
Are there any foods you exclude from your diet? _____
What foods are in a typical breakfast, lunch, dinner, snack(s) for you?

_____
_____
_____
_____

Please circle the appropriate answer for each of the following areas:

Health:	Great	Good	Average	Poor	Bad
Diet:	Great	Good	Average	Poor	Bad
Exercise:	Great	Good	Average	Poor	Bad
Career:	Great	Good	Average	Poor	Bad
Family:	Great	Good	Average	Poor	Bad
Significant Other:	Great	Good	Average	Poor	Bad
Sex:	Great	Good	Average	Poor	Bad
Self :	Great	Good	Average	Poor	Bad
Spirituality:	Great	Good	Average	Poor	Bad
Sleep:	Great	Good	Average	Poor	Bad

Sleep:

What time do you go to bed? _____ What time do you wake? _____

Average number of hours of sleep? _____ Do you feel rested when you wake? ___

Do you have problems falling asleep? ____ If yes, please explain_____

_____

Do you wake during the night? ____ How many times? _____ What causes you to wake? _____

Women:

Are you pregnant? _____ if yes how many weeks along? _____

if no, are you trying to get pregnant? _____

# of pregnancies ___ # of live births ____ # of miscarriages ___ # of abortions ___

Have you been diagnosed with:

Ovarian cysts: _____ Fibroids: _____ Fibrocystic Breast: _____ PID: _____

Endometriosis: _____ Other: _____

Number of days between periods: _____ Number of days of flow: _____

Color of flow: _____

Are there clots?: _____ If yes, what size?(dime, nickel, quarter): _____

Do you experience PMS symptoms?: ____ If yes, please describe: _____

_____

Average number of tampons/pads used per day:

1st: _____ 2nd: _____ 3rd: _____ 4th: _____ 5th: _____ 6th: _____ 7th: _____

Symptoms Survey (for everyone):

Please mark the following symptoms with:
(X) if you experience them occasionally
(+) if you experience them frequently
( ) leave blank if you do not experience them

( ) high cholesterol
( ) high blood pressure
( ) intolerance to weather
( ) numbness/tingling
( ) cold hands/feet
( ) recent use of antibiotics
( ) nightmares
( ) vivid dreams
( ) heart palpitations
( ) irregular heart beat
( ) ear ringing/tinnitus
( ) lack of appetite
( ) excessive appetite
( ) soft/brittle nails
( ) sudden weight loss/gain
( ) diarrhea/loose stools
( ) constipation
( ) hemorrhoids
( ) acid reflux/heart burn
( ) burping/belching
( ) vaginal discharge
( ) abdominal pain/cramping
( ) indigestion/digestive problems
( ) difficulty digesting
( ) easily angered/agitated
( ) laughing for no reason
( ) difficulty making decisions

( ) cough
( ) shortness of breath
( ) low back pain/weakness
( ) decreased sense of smell
( ) nasal problems
( ) acne
( ) rashes
( ) bronchitis
( ) frequent colds/flu
( ) colitis/diverticulitis
( ) Carpal Tunnel Syndrome
( ) decreased vision
( ) floaters in vision
( ) dry/itchy/red eyes
( ) spasms/twitching of muscles
( ) knee pain/weakness
( ) decreased hearing
( ) urinary problems
( ) kidney stones
( ) gallstones
( ) blood in stool
( ) black tarry stool
( ) bruise easily
( ) light colored stool
( ) sciatic pain
( ) mental restlessness
( ) difficulty digesting oily/greasy foods

( ) asthma
( ) allergies
( ) hay fever
( ) fainting
( ) headache
( ) migraine
( ) dizziness
( ) insomnia
( ) vomiting
( ) nausea
( ) chest pain
( ) angina
( ) edema
( ) fatigue
( ) hair loss
( ) gas
( ) TMJ
( ) IBS