# Patient Information

**Vibrant Health Acupuncture & Wellness Center, LLC**
**260 Gateway Drive, Suite 7B**
**Bel Air, Maryland 21014**
**410-913-8322**

**Patient Name:** ____________________

**Date of Birth:** ____________ **Age:** ______ **Male:** ______ **Female:** ______

**Single:** ______ **Married:** ______ **Separated:** ______ **Divorced:** ______ **Widowed:** ______

**Street Address:** ____________________

**City:** ____________ **State:** ____________ **Zip Code:** ____________

**Home Phone:** ____________ **Cell Phone:** ____________

**Email:** ____________________

**Occupation:** ____________ **Employer:** ____________

**Insurance Company:** ____________________

**Emergency Contact:**

**Name:** ____________ **Phone #:** ____________

**How did you hear about us?:** ____________________

I understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment or coverage. I authorize the release of medical information to my insurance company, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company to pay directly to Vibrant Health Acupuncture & Wellness Center, LLC. for those medical services. I understand that any outstanding account balances will be sent to collections after 90 days if payment has not been remitted.

Date: ____________

Patient Signature: ____________________

# Health History Questionnaire

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**Major Complaint(s):**

- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

**How do these conditions affect your daily activities?:** ______________________________

______________________________

**Primary Physician:** ______________________________

**Other physicians/therapists:** ______________________________

**Medication(s) you are currently taking:**

| Drug Name | Taking For | Taking Since |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Supplements (vitamins, herbs, minerals, etc.):** ______________________________

______________________________

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# Health History Questionnaire

| List all hospital stays, surgeries, or major illnesses that you have had since birth | Year Occurred |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| Test | Year | Test Results |
|---|---|---|
| Physical | ________ | ____________________ |
| Cholesterol | ________ | ____________________ |
| Prostate | ________ | ____________________ |
| Mammogram | ________ | ____________________ |
| Pap Smear | ________ | ____________________ |
| Blood | ________ | ____________________ |
| HIV/STD | ________ | ____________________ |

Please check if you have or had any of the following conditions

| | | | |
|---|---|---|---|
| Diabetes | Syphilis | Mumps | Jaundice |
| Heart Disease | CVA (Stroke) | Rheumatic Fever | Hepatitis |
| Asthma | Pneumonia | Emphysema | Vein Condition |
| Allergies | Gonorrhea | Bleeding Tendency | Tuberculosis |
| Meningitis | Measles | High Blood Pressure | Chicken Pox |
| Epilepsy | HIV | Nervous Disorder | Polio |
| Paralysis | High Fever | Mononucleosis | Migraines |
| Glaucoma | Cancer | Multiple Sclerosis | Anxiety |

Health History Questionnaire

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**Please check all the symptoms that you are currently experiencing or have experienced in the last 6 months.**

**What makes the pain better?**
- Soft pressure
- Hard pressure
- Cold
- Heat
- Exercise
- Rest
- Other: ____________________________

**What makes the pain worse?**
- Soft pressure
- Hard pressure
- Cold
- Heat
- Exercise
- Rest
- Other: ____________________________

**TOTAL BOXES CHECKED: _________**

## Describe Your General Pain

- Sharp
- Fixed
- Burning
- Moving
- Cramping
- Aching
- Dull
- Other: ____________________________

**TOTAL BOXES CHECKED: _________**

## Lung & Kidney Function (Overall Temperature)

- Shortness of breath
- General weakness
- Daily chronic fatigue & malaise
- Low energy
- Difficulty keeping eyes open (daytime)
- Easily catch colds
- Feel worse after exercise

**TOTAL BOXES CHECKED: _________**

## Liver, Spleen, Heart Function

- Dizziness
- See floating black spots

**TOTAL BOXES CHECKED: _________**

## Heart Function

- Anxiety
- Sores on tip of tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Trouble falling and/or staying asleep

**TOTAL BOXES CHECKED: _________**

# Health History Questionnaire

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## Pancreas/Spleen Function

Low appetite
Abrupt weight gain
Abrupt weight loss
Abdominal bloating
Abdominal gas
Worry
Gurgling noise in stomach
Fatigue after eating
Bruise easily
Prolapsed organs: ______________________
Overthinking

**TOTAL BOXES CHECKED: __________**

## Small/Large Intestine Function

Loose stools
Constipated
Incomplete stools
Diarrhea
Blood in stools
Mucous in stools
Undigested food in stools

**TOTAL BOXES CHECKED: __________**

## Lung Function

Nasal discharge (color: ________________)
Cough
Nose bleeds
Sinus congestion
Allergies (type: ________________________)
Alternation of chills/fever
Dry mouth
Dry throat
Dry nose
Dry skin
Sneezing
Headache (location: ___________________)
Overall achy feeling in body
Stiff neck
Stiff shoulders
Sore throat
Difficulty breathing
Smoke cigarettes (packs per day: _______)
Sadness
Melancholy

**TOTAL BOXES CHECKED: __________**

## Stomach Function

Burning sensation after eating
Large appetite
Bad Breath
Canker sores (mouth)
Bleeding, swollen or painful gums
Heartburn
Acid regurgitation
Ulcer
Belching
Hiccups
Stomach pain
Vomiting

**TOTAL BOXES CHECKED: __________**


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## Dampness Trapped in the Body

| | |
|---|---|
| Bodily sensation of heaviness | Swollen feet |
| Mental heaviness | Swollen joints |
| Mental sluggishness | Chest congestion |
| Mental fogginess | Nausea |
| Swollen hands | Snoring |

**TOTAL BOXES CHECKED: _________**


## Dampness Trapped in the Body

| | |
|---|---|
| Bodily sensation of heaviness | Swollen feet |
| Mental heaviness | Swollen joints |
| Mental sluggishness | Chest congestion |
| Mental fogginess | Nausea |
| Swollen hands | Snoring |

**TOTAL BOXES CHECKED: _________**


## Liver Function (Eyes)

| | |
|---|---|
| Itchy | Gritty |
| Bloodshot | Blurry vision |
| Hot | Decreased night vision |
| Dry | Near sighted |
| Watery | Far sighted |

**TOTAL BOXES CHECKED: _________**

## Liver, Gall Bladder Function

| | |
|---|---|
| Alternating diarrhea & constipation | Muscle spasms |
| Chest pain | Seizures |
| Tight sensation in chest | Convulsions |
| Bitter taste in mouth | Lump in the throat |
| Anger easily | Neck tension |
| Depression | Shoulder tension |
| Frustration | Limited range of motion in neck |
| Irritability | Limited range of motion in shoulder |
| Skin rashes | Alcohol consumption (per day: _________) |
| Headache at the top of the head | Recreational drug use (which: _________) |
| Tingling sensation | High-pitched ringing in ears |
| Numbness | Gallstones |
| Muscle twitching | STD's (which: ________________________) |
| Muscle cramping | Unable to adapt to stress |

**TOTAL BOXES CHECKED: _________**

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# Health History Questionnaire

## Kidney Function (Overall Temperature)

Cold hands
Cold fingers
Cold feet
Cold toes
Sweaty hands
Sweaty feet
Hot body temp. sensation
Cold body temp. sensation

Afternoon flushes
Night sweats
Heat in the hands, feet & chest
Hot flashes any time of the day
Thirsty
Perspire easily
Lack of perspiration

Do you take water to bed

**TOTAL BOXES CHECKED: _________**

## Kidney (Urinary Bladder Function)

Frequent cavities, teeth problems
Easily broken bones
Sore knees
Weak knees
Cold sensation in knees
Low back pain
Memory problems
Excessive hair loss

Low-pitched ringing in ears
Kidney stones
Bladder infections
Lack of bladder control
Wake during the night to urinate
Fear
Easily Startled

**TOTAL BOXES CHECKED: _________**

## Urination (Bladder Function)

Color: Pale ___ Dark Yellow ___ Clear ___
Reddish
Cloudy
Scanty
Profuse
Strong odor

Burning sensation
Painful
Discharge
Difficult
Urgent

Frequent

**TOTAL BOXES CHECKED: _________**

## Libido

Low
Normal
High

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# Health History Questionnaire

## WOMEN ONLY

| | | |
|---|---|---|
| Do you have a regular menstrual cycle?: | Yes | No |
| Are you pregnant?: | Yes | No |
| Do you have bleeding between periods? | Yes | No |
| Do you have a vaginal discharge? | Yes | No |

### Menstrual Cycle Symptoms

| | |
|---|---|
| Nausea | Migraines |
| Vomiting | Dull pain |
| Food cravings | Sharp pain |
| Water retention | Depression |
| Breast swelling | Irritability |
| Breast tenderness | Anxiety |
| Headaches | Other: ______________________________ |

**TOTAL BOXES CHECKED: _________**

## MEN ONLY

| | |
|---|---|
| Swollen testes | Premature ejaculation |
| Testicular pain | Coldness or numbness external genitalia |
| Impotence | Other: _____________________________ |

**TOTAL BOXES CHECKED: _________**

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