Good Vibes Cathy

HEALTH HISTORY QUESTIONAIRE

All information contained in this questionnaire are strictly confidential.

Date:

Name: ☐ **M** **DOB:**

(Last, First, MI) ☐ **F**

Primary Care Physician: **Phone number:**

Other healthcare practitioners:
Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists, etc.:

Name:	Type of practice:	Phone number:

Date of last physical exam:	Date of last pap Or prostate exam:	Date of last Fasting blood labs:

Please list your current health concerns in order of their importance to you:

Concern:	Date of last onset:
1.	
2.	
3.	
4.	
5.	

Current or Previous medical diagnosis:

Diagnosis:	Diagnosis by:	Date of diagnosis:
1.		
2.		
3.		
4.		
5.		

Traumas, Car Accidents, Injuries:

Surgeries and Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? YES NO Date:

Good Vibes Acupuncture & Herbs ~ Cathy Margolin, L.Ac. Dipl. OM ~
Bend, OR 97703 ~ Phone ~ 310-464-7397 ~

Childhood Medical History

Prenatal history: Any complications during your mother's pregnancy with you? ☐ **Yes** ☐ **No**
If so, describe:

Birth History: □ Vaginal □ Cesarean Section □ Forceps □ Vacuum □ Trauma?
Any newborn problems? □ Jaundice □ Hospitalization □ Other, describe

Nourishment: As a baby, were you fed □ Breast milk □ Formula □ Mixed
Do you know at what age you first were given solid foods?
How would you describe your diet as a child?

Childhood Illness: How often did you get sick as a child?
What kind of illnesses did you usually experience? i.e. ear infections, sore throat, cough, allergies, asthma…

How often did you take antibiotics?
Other medications taken regularly as a child?
Did you ever have:
□ Measles □ Mumps □ Chicken Pox □ Rheumatic Fever
□ Polio □ Pertussis □ Other infectious diseases

List any other medical problems you had as a child:

Vaccinations: ☐ I am fully vaccinated

☐ I am selectively vaccinated

☐ I am not vaccinated

Last tetanus booster:

Do you get the flu vaccine? ☐Yes ☐ No

Any adverse reactions to vaccine? ☐Yes ☐ No

Check those vaccinations you've had:

☐ Chicken Pox ☐ Polio

☐ DPT ☐ PPD

☐ Hepatitis ☐ MMR

☐ HIB ☐ Pneumonia

Home Environment:
How many children in your family? Your birth order (3rd of 4 kids….)
What adults lived with you?
Did you have any traumas or losses as a child?
Was your home safe?
Did you grow up in the city, suburbs, or in a rural area?
Any difficulties in school?
Did anyone in your home smoke or use drugs regularly?

FAMILY HEALTH HISTORY

Are you adopted?.. ☐ Yes ☐ No

Family history, note relationship below.

☐ High blood pressure	☐ Diabetes	☐ Allergies	☐ Epilepsy
☐ Tuberculosis	☐ Stroke	☐ Cancer	☐ Substance Abuse
☐ Heart disease	☐ Kidney disease	☐ Obesity	☐ Osteoporosis
☐ Thyroid disorder	☐ Arthritis	☐ Autoimmune disease	☐ Other

Relationship	Age	Age at Death	Significant health problems or cause of death:	Children's Age	Age at death:	Significant health problems or cause of death:
Father				□ M □ F		
Mother				□ M □ F		
Brothers And sisters □ M □ F				□ M □ F		
□ M □ F				Grandparents (mother's Side)		
□ M □ F				Male		
□ M □ F				Female		
□ M □ F				Grandparents (Father's side)		
□ M □ F				Male		
□ M □ F				Female		

Please leave this space blank for physician use.

MEDICATIONS		
Prescription Medications	Strength	Frequency Taken
Over The Counter Drugs	Strength	Frequency Taken
Vitamins and Other Supplements	Strength	Frequency Taken

ALLERGIES	
Name of Drug	Reaction
Allergies to Foods:	
Environmental Allergies:	
Notes:	

DIET	
Diet:	Do you describe your diet as: ☐ Vegetarian ☐ Vegan ☐ Macrobiotic ☐ Other Do you restrict calories?...................................... ☐ Yes ☐ No How often do you eat? # of times you eat restaurant food each week? Where do you grocery shop? Do you buy organic foods? What %? Foods you restrict: What foods do you crave? Any foods you strongly dislike? Have you ever had an eating disorder? Describe what you have eaten in the last 24 hours, be specific… Time: Food eaten-describe ingredients Amount __________ __________ __________ __________ __________ __________ Water (how much): Source: □ Tap □ Brita □ Bottled □ Filtered □ Well Other beverages: How often do you eat the following: Fish Fresh Vegetables Red meat Dark leafy greens Eggs Citrus fruits Dairy Sweets Wheat Fruit juice Salads List any food allergies or intolerances: Food eaten Reaction Timing __________ __________ __________

OTHER LIFESTYLE FACTORS

Activity: ☐ Sedentary (no exercise)

☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)

☐ Occasional Vigorous Exercise (i.e. work or recreation **less** than 4x/week for 30 min.)

☐ Regular Vigorous Exercise (i.e., work or recreation 4x/wk. for 30 min.)

After moderate or vigorous exercise, do you feel ☐ great ☐ drained

Weight: Current weight: _________ ☐ Don't know

Ideal body weight: ____________

What is the most ______and least _________ you have weighed as an adult? (excluding pregnancies)

Do you have, or have you ever had, an eating disorder?....................☐ Yes ☐ No

☐ Binging ☐ Purging ☐ Avoidance of food

Do you diet or lose weight?.. ☐ Yes ☐ No

Do you take medications, herbs or supplements to lose weight? ☐ Yes ☐ No

For physician to fill out:

BMI

HOME Is your home a sanctuary for you?...☐ Yes ☐ No

Do you live in an ☐ apartment ☐ house ☐ other Year building was built?

Who lives with you?

Name	Relationship

Do you live with animals? If so, describe.

Does your home have lead paint…………………………………………......☐ Yes ☐ No

Is your home moldy?...☐ Yes ☐ No

Do you have ☐ telephone ☐ electricity/heat ☐ enough food

Is your home safe? ………………………………………………………☐ Yes ☐ No

Is there a gun in your home? ……………………………………………☐ Yes ☐ No

OCCUPATION Do you work primarily inside the home?.................................. ☐ Yes ☐ No

Do you work outside the home?..☐ Yes ☐ No

If so, what type of work?

How many hours a week do you work?_____How many days a week?_____

Do you spend most of your day at a desk or computer?.................☐ Yes ☐ No

Do you take vacations?..☐ Yes ☐ No

Are you happy in your work? ☐ Yes ☐ No

Comments:

HOBBIES What do you do for fun? ____

What do you like to do in your spare time?

HABITS

Alcohol:

Do you drink alcohol?.. ☐ Yes ☐ No
If yes, what kind? ___________________ How many drinks per week? ________
Are you concerned about the amount you drink? ………..☐ Yes ☐ No
Have you considered stopping?.. ☐ Yes ☐ No
Have you ever experienced blackouts?............................... ☐ Yes ☐ No
Are you prone to "binge" drinking? ………………………☐ Yes ☐ No
Do you drive after drinking?.. ☐ Yes ☐ No

Tobacco:

Do you use tobacco?... ☐ Yes ☐ No
☐ Cigarettes-pks/day ☐ Chew-# day ☐ Pipe- #/day
☐ Cigars- #/day ☐ # of years ☐ or Year Quit

Drugs:

Do you currently use recreational or street drugs?.............. ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle?..... ☐ Yes ☐ No

Caffeine:

Coffee……………………………..☐ Yes ☐ No Amount:
Soda……………………………… ☐ Yes ☐ No Amount:
Caffeinated tea……………………☐ Yes ☐ No Amount:
Other……………………………..☐ Yes ☐ No Amount

TOXIC EXPOSURES			
	☐ Pottery	☐ Nuclear power plant	☐ Asbestos
	☐ Glass blowing	☐ Frequent Air Travel	☐ Second hand smoke
	☐ Painting	☐ Electric power lines	☐ Other solvents
	☐ Model building	☐ Mercury fillings	☐ Other heavy metals
	☐ Cleaning chemicals	☐ Other mercury exposure	☐ Pesticides
	☐ Anesthesia	☐ Lead paint	☐

Notes for physician:

SEXUAL AND REPRODUCTIVE HEALTH FOR PREMENOPAUSAL WOMEN

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Menstrual History

What age did you first menstruate?__________
What was the first day of your most recent period? ___________
How long is your cycle, month to month?________
Is your cycle length regular?________
How many days do you bleed?______
Is your flow □ light □ moderate □ heavy
PMS? □ Yes □ No Describe:
Do you skip periods? □ Yes □ No
Any mid cycle spotting? □ Yes □ No

Menstrual Symptoms

Check if you experience any of the following:

□ Cramps
□ Swelling
□ Breast tenderness
□ Mood swings
□ Anxiety, Irritability
□ Cravings Describe: _________
□ Fatigue
□ Confusion
□ Acne
□ None

Gynecologic Conditions

Check if you have had any of the following?

□ Genital Herpes
□ Genital warts
□ Gonorrhea
□ Chlamydia
□ Syphilis
□ Hepatitis
□ HIV
□ PID
□ Yeast Infection
□ Bacterial Vaginosis
□ Trichimonas
□ PCOS
□ Endometriosis
□ Uterine fibroid
□ Ovarian Cyst
□ Breast lump
□ Fibrocystic breasts
□ Nipple discharge
□ Pain with intercourse
□ DES exposure
□ Itching, odor, discharge
□ None

Sexual History

Are you sexually active? □ Currently □ past □ never
Age you were first consensually sexually active? _______
Partners? □ Male □ Female □ Both
Are you in a monogamous relationship? □ Yes □ No
Total number of different sexual partners ___________
How many of these have been within the last year? _____
Do you have difficulty having an orgasim? □ Yes □ No
Do you feel knowledgeable about safe sex? □ Yes □ No
Do you practice safe sex? □ Yes □ No
Have you ever been raped? □ Yes □ No Age? ______
□ Once □ Often? Number of times _______
Have you ever been sexually abused/molested? □ Yes□ No
Any other concerns? □ Yes □ No
Have you ever had an STD screening? □ Yes □ No
Have you ever had an abnormal pap? □ Yes □ No
Date of last annual gyn exam with pap? ____________

Pregnancy History:

Date:	Outcome	Breastfed? How long?

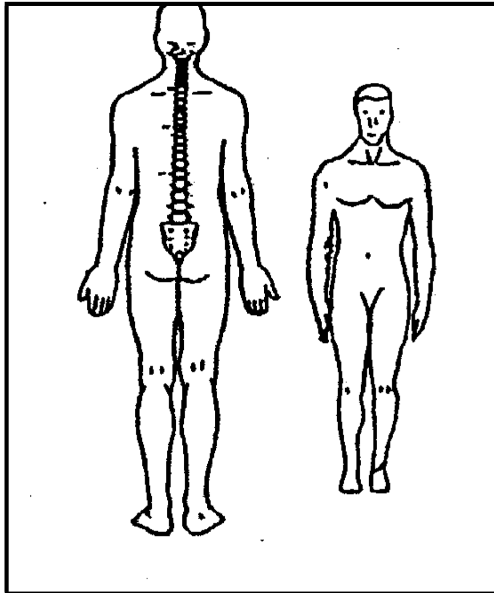
Are you currently pregnant? ……………………………………………….□ Yes □ No
Do you plan to become pregnant in the future?.. □ Yes □ No
If so, when?
Have you ever had difficulty getting or staying pregnant?...................................... □ Yes □ No

Contraceptive History: What birth control methods have you used? *(Fertility awareness, condoms, sponge, cap, diaphragm, IUD, oral contraceptives, norplant, Depo-provera…)*

Type:	How long?	Any problems?	Current Use?

REVIEW OF SYSTEMS		
Check if you have, or have had, concerns in the following areas to a significant degree. Also note any recent changes in the areas listed below.		
CONSTITUTIONAL		
□ Weight □ Energy level □ Sleep	□ Appetite □ Strength □ Night sweats	□ Sense of well-being □ Libido
EYES, EARS, NOSE, MOUTH, THROAT		
□ Vision loss □ Double vision □ Excessive tearing □ Dry eyes □ Blind spots □ Eye pain □ Eye discharge	□ Hearing loss □ Ringing in the ears □ Vertigo/dizziness □ Nose bleeds □ Chronic stuffy nose □ Post nasal drip □ Recurrent sinus infections	□ Headaches □ Missing teeth □ Gingivitis □ Bad breath □ Neck stiffness or swelling
HEART AND BLOOD VESSELS		
□ Chest wall pain □ Palpitations □ Short breath w/mild exercise □ Short of breath lying flat	□ Heart murmur □ Varicose veins □ Clotting disorder □ Vessel inflammation	□ Fainting □ Swelling □ Leg pain when walking □ Anemia
LUNGS		
□ Painful breathing □ Shortness of breath	□ Wheezing □ Cough □ Chronic bronchitis	□ Coughing sputum □ Coughing blood
MUSCULOSKELETAL		
□ Back pain □ Scoliosis □ Bone loss/fractures	□ Muscle weakness □ Muscle cramps □ Muscle pain	□ Joint pain □ Morning stiffness □ Hot/red muscles or joints □ Limited range of motion
NEUROLOGIC AND PSYCHOLOGICAL		
□ Seizures, convulsions □ Paralysis □ Numbness/tingling □ Tremor	□ Lack of coordination □ Speech difficulties □ Anxiety □ Depression	□ Bipolar disorder □ Suicidal history
IMMUNE SYSTEM		
How many times a year do you get sick? Do you recover easily? □ Lymph node swelling		
ENDOCRINE		
□ Breast enlargement-men □ Thyroid problems □ Heat or cold intolerance □ Excessive urination □ Excessive thirst	□ Spacey feeling after food □ Waking at night □ Fainting □ Swelling □ Leg pain when walking	

ELIMINATION		
GUT	How often do you have a bowel movement? ________ Is your stool: □ Formed □ Loose □ Hard □ Dry □ Greasy □ Brown □ Tan □ Black □ Green □ Yellow In your stool, do you ever notice: □ Undigested food □ Bright red blood □ Mucous Do you strain to pass stool?... □ Yes □ No Do you have hemorroids?... □ Yes □ No Do you experience gas, bloating, or belching daily?....... □ Yes □ No Do you ever unintentionally pass stool?.......................... □ Yes □ No	
	□ Abdominal pain □ Heartburn/indigestion □ Nausea/ vomiting	□ Recent change in bowel movements □ Constipation □ Diarrhea
KIDNEYS	How often do you urinate? Do you have any of the following? □ Pain with urination □ Urinate too frequently/too much □ Urgency to urinate □ Urinary flow obstruction □ Dribbling at end of urination □ Recurrent urinary tract infections	□ Must get up at night to urinate □ Leaking urine □ when laughing or coughing □ at other times □ Kidney Stones
SKIN	Do you sweat easily? What makes you sweat? Do you regularly apply lotion or oils to your skin? If so, what type? Do you scrub or dry brush your skin regularly? Note if you have or have had any of the following: □ Acne □ Eczema □ Rash □ Chronic itching □ Dry skin □ Contact dermatitis	□ Moles □ Hives □ Pigment changes □ Skin cancer □ Hair loss or unusual growth □ Jaundice—yellowing of the skin
LUNGS	Note if you have had any of the following: □ Asthma □ Can't sleep flat □ Chronic cough □ Painful breathing □ Difficulty breathing □ Recurrent lung infections	
LIVER	Note if you have had any of the following: □ Yellowing of the skin □ Chronic itching □ Nausea/vomiting □ Abdominal pain □ PMS □ Menstrual irregularities	Are you unable to tolerate: □ Cigarette smoke □ Perfume □ Alcohol □ Caffeine



Please indicate on the drawings the location and type of symptoms that you are experiencing.

A = Aching
B = Burning
SB = Stabbing PN
= Pins /Needle N
= Numbness
SPT = Spasm/ Tight

Write out any other problems

Financial Policy

Thank you for choosing Good Vibes Acupuncture & Herbs. We are committed to providing the best medical care possible. The following statement explains our financial policy which we ask you to read, sign and return to us prior to your treatment. Complementary Medicine may be covered by some PPO plans. Check with your insurance company to determine if this is a covered benefit.

Returned Checks

For checks returned to us as unpaid by your bank, you will be charged a ***$25 fee***.

Missed Appointments

Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge ***$25 for missed appointments without appropriate notice***. Please help us to serve you better by keeping scheduled appointments.

Payment Plans

If you are unable to pay your balance in full at the time of your visit, payment arrangements may be made. Please discuss your situation with Cathy Margolin L.Ac. so she can create a plan for you

Past Due Accounts

If a payment plan is not in place and your account becomes overdue, your account will be referred to a collection agency. Legal fees that we incur to secure past due balances will be added to your account.

Consent to Treat

I consent to the use and/or disclosure of my protected health information to Cathy Margolin L.Ac. for purposes of diagnosing or providing treatment to me or obtaining payment for my health care bills. I consent to treatment and understand that my physician is a licensed Acupuncturists and Diplomate of Eastern Oriental Medicine Physician. I understand and agree that diagnosis or treatment of me and my physician may be conditioned upon my consent as evidence by my signature on this document. I understand that I am financially responsible for the charges that I incur during my treatment under the care of Cathy Margolin. I have read and agree to the financial policy. Please request a copy of our Privacy Practices if you have any questions or concerns.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE, I AM RESPONSIBLE FOR THE BALANCE ON THIS ACCOUNT FOR ANY SERVICES, SUPPLEMENTS, MEDICINES, AND LABORATORY WORK.

Print Name of Patient ____

Signature of Patient ____

Date_________________