Client Information and Health History Questionnaire

*Please take the time to print and fill out this questionnaire as completely as possible, or as completely as you are comfortable, prior to your first visit. All of your answers will be held absolutely confidential and will only be used for the purposes of providing best possible care for your case. If you have any questions, please ask. Please include in the **"Comments"** section anything or any problems that you would like to discuss that are not included in this form.*

Date: _____

General Information				
Full Name:				
Address:				
City:	State:	Zip:		
Phone:	Email:			
Preferred Contact Methods (check all applicable): Phone Text Email Other:				
May we send you information regarding Indigo's services and discounts (emails sent 1x/month)? Yes No				
Birth Date (include time if known):	Birthplace:			
Birth Sex (circle): M F	What gender do you identify as?			
Relationship Status (circle): Single Partnered Married Divorced Widowed Other:				
Number and ages of children:				
With whom do you live (circle all applicable)? Spouse Partner Parents Ext. Family Roommates Children Alone				
Occupation:				
Age:	Height:	Weight:	Weight 1 year ago:	Max weight:
Are you currently pregnant? Yes No				
Are you currently under the care of a physician (MD)? Yes No				
(if yes) Name:	Address: Phone:			
Emergency Contact Name (local):				
Emergency Contact Relationship:	*Emergency Contact Phone:*			
How did you hear about us?				
Is this your first time receiving acupuncture treatment (circle)? Y N				

History of Chief Complaint
What is the **main** reason for your visit today?
Describe how and when the problem first began.
Have you received a formal medical diagnosis for this problem? If so, what?
What treatments have you tried and what were the outcomes?
In general, what have you noticed makes it better or worse? When is it better or worse?
Is the problem persistent or does it come and go?
On a scale of 1 to 10, to what extent does the problem interfere with your daily activities, or affect your quality of life? Explain.
What other health concerns or health goals do you have that you would like assistance with?

Past Medical History
When did you last visit a doctor's office, medical clinic, or hospital?
What was the reason?
What hospitalizations, surgeries, exploratory procedures (biopsy, etc), or dental procedures have you had? List dates and outcomes.

Past Medical History

Do you take any of the following more than once per week (circle)?

Pain Relievers (Aspirin/Ibuprofen/etc) Diet Pills/Appetite Suppressants Antacids/Reflux Medications

Laxatives Cortisone (cream or pills) Sleeping Pills Antibiotics Blood Thinners Anti-depressants

Please list the names of any prescription or over the counter medications, vitamins, or other supplements you are currently taking:

Are you aware of any allergies to foods, drugs, or other environmental allergens (cats, mold, dust, ragweed)? If yes, please list and explain.

Do you have any active infections that you are aware of? Yes No

If yes, what?

Do any of the following conditions/diagnoses apply?

(Circle. Y = Yes, present problem. N = No, never had this problem. P = Past problem. F = Family history.)

Arrhythmia: Y N P F	Cancer: Y N P F	Chemical Dependency (alcohol, nicotine, etc): Y N P F	Dermatological (Skin) Disorder: Y N P F
Diabetes: Y N P F	Eye Disease: Y N P F	Gastrointestinal Disorder (reflux, Crohn's, etc): Y N P F	Genetic Disorder: Y N P F
Immune Disorder: Y N P F	Heart Disease: Y N P F	High Blood Pressure: Y N P F	Infertility: Y N P F
Kidney Disease: Y N P F	Liver Disease/Hepatitis: Y N P F	Lung Condition (asthma, allergies, etc): Y N P F	Lyme Disease: Y N P F
Mental/Mood Disorder: Y N P F	Neurological Disease (Alzheimer's, Parkinson's, etc): Y N P F	Obesity: Y N P F	Parasites: Y N P F
Post-Traumatic Stress Disorder: Y N P F	Rheumatic Fever: Y N P F	Sleep Disorder: Y N P F	Stroke: Y N P F
Thyroid Disorder: Y N P F	Tuberculosis: Y N P F		

Past Medical History
List any other significant conditions/diagnoses not mentioned above, particularly any active infections:
List any other significant conditions that exist in your family medical history:
What childhood illnesses/conditions/learning disabilities did you have? How often were you put on antibiotics?
Were there any complications or difficult circumstances surrounding your birth or early infancy? (C-section, forceps, cord wrapped around neck, family conflict or stress, mother's illness, etc.)
List any major physical traumas you've experienced (falls, sprains, fractures, concussions, car accidents, etc.):
Do you have any scars? Where?
List any significant shocks that have occurred in your life (death of loved one, loss of job, divorce, etc.)
Are you currently/regularly exposed to any toxic materials, or have you ever had such exposure (to industrial chemicals, toxic mold, radiation, etc)? If so, what?
List any trips you've made outside of the country (where and when).

Lifestyle and General Health
On a scale of 1 to 10, how would you rate your overall health?
On a scale of 1 to 10, how would you rate your average stress level?
What are your biggest sources of stress?
On a scale of 1 to 10, how would you rate your overall life satisfaction?
On a scale of 1 to 10, how would you rate your family relationships?
On a scale of 1 to 10, how would you rate your friendships?
On a scale of 1 to 10, how would you rate your sexual/dating/married life?

Lifestyle and General Health

On a scale of 1 to 10, how would you rate your living situation?
On a scale of 1 to 10, how would you rate your job satisfaction?
On a scale of 1 to 10, how would you rate your overall energy level?
What time of day is your energy best? When is the worst?
How much water do you drink in a day?
What other non-alcoholic beverages do you drink on a regular basis? How much?
How many alcoholic beverages do you drink in a week?

Do you smoke? If so, how much and are you interested in quitting?	Have you/do you use any recreational drugs?

How would you characterize your overall diet now (omnivore, vegetarian, vegan, etc.)?
Was your diet significantly different in the past? If so, describe how.
Do you have strong cravings for any particular foods or flavors? If so, what?
Any foods or flavors you strongly dislike?

Typical meals eaten during...

Breakfast	Lunch	Dinner	Snacks
Time:	Time:	Time:	Time(s):

Eating Habit Index *(U = Usually, S = Sometimes, N = Never)*

I eat at regular times.	U	S	N		I chew my food throughly.	U	S	N	
I eat when I'm hungry.	U	S	N		I prepare my own meals.	U	S	N	
I snack often.	U	S	N		I eat hot/cooked meals.	U	S	N	
I eat alone.	U	S	N		I enjoy preparing my own food.	U	S	N	
I eat with others.	U	S	N		I sit down when I eat.	U	S	N	
I eat until I am uncomfortably full.	U	S	N		I eat on the go/in my car.	U	S	N	
I discuss work/do work while eating.	U	S	N		I find meal time enjoyable and relaxing.	U	S	N	

Lifestyle and General Health

What time do you normally go to bed?	How many hours of sleep do you normally get?	Do you wake feeling well rested?
Are you sexually active?	Do you use protection?	
Do you regularly exercise? How often? What activities?		
How many hours a day do you spend in front of a television or computer screen?		
What are the main physical demands of your job (circle all applicable)? Sitting Standing Lifting Twisting Bending Turning neck Climbing stairs Driving Walking Other:		

Review of Systems

Circle.
N = No, never had this problem.
Y = Yes, I currently have or experienced this problem in the last 6 months.
P = I have experienced this problem in the past but not in the last 6 months.

Musculoskeletal/Pain/Orthopedic/Neurological (Other: _____)

Are you right handed or left handed? _____

Frozen Shoulder	Y	N	P		Arthritis	Y	N	P	
Sciatica	Y	N	P		Torn Ligament	Y	N	P	
Scoliosis	Y	N	P		Bone Spurs	Y	N	P	
Broken Bones	Y	N	P		Gout	Y	N	P	
Muscle atrophy	Y	N	P		Bulging spinal disc	Y	N	P	
Loss of function/paralysis	Y	N	P		Muscle weakness	Y	N	P	
Shingles	Y	N	P		Difficult/loss of balance	Y	N	P	
Numbness/Tingling	Y	N	P		Tremors	Y	N	P	
Referred pain	Y	N	P		Hypermobile Joints	Y	N	P	
Joint pain	Y	N	P		Poor coordination	Y	N	P	
Muscle spasms/twitches	Y	N	P		Fibromyalgia	Y	N	P	
Epilepsy/Seizures	Y	N	P						

Review of Systems

On the following diagram:

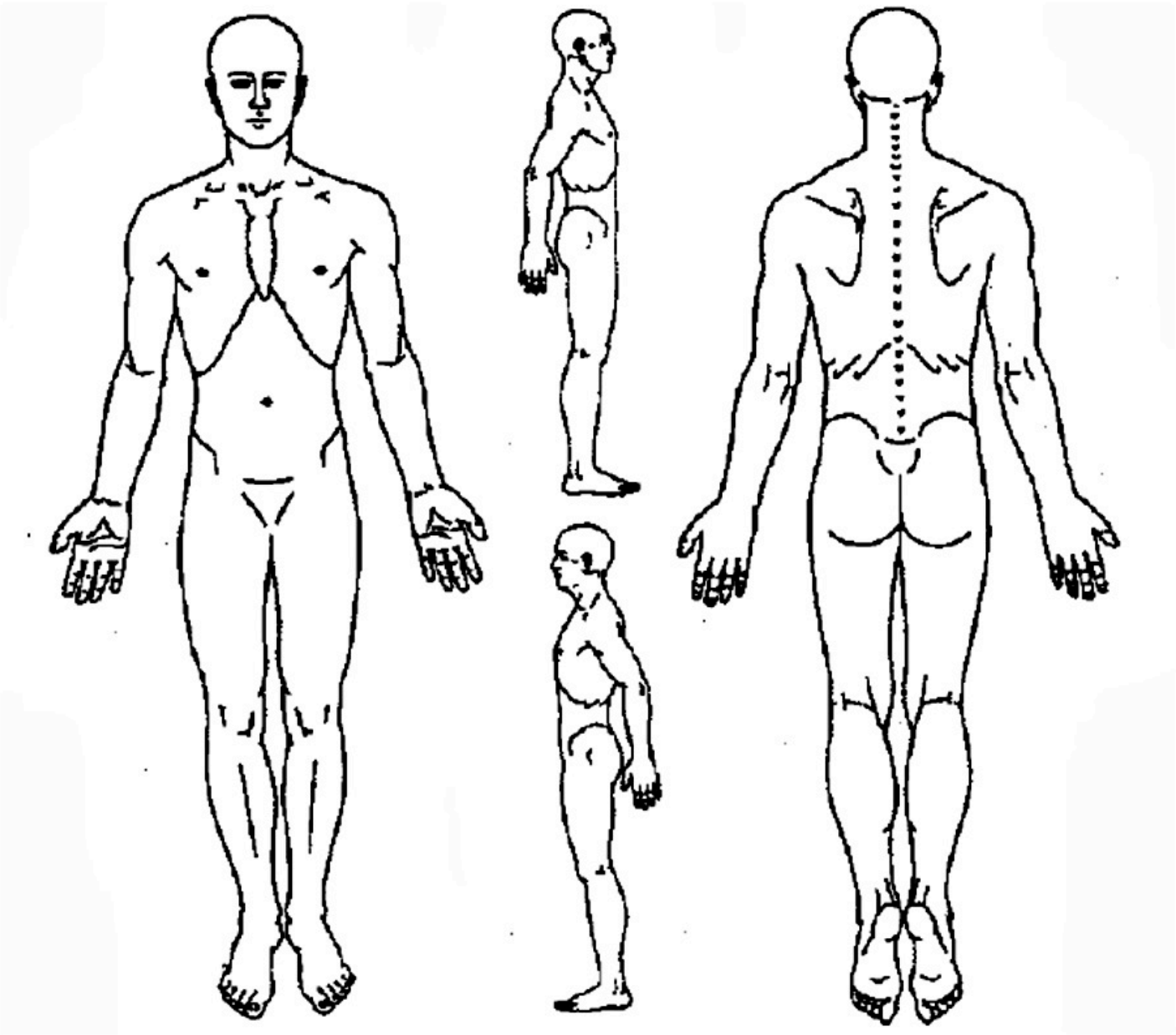
1) Mark where on your body you feel discomfort with the appropriate symbol:

O = Dull/Sore/Achey **X** = Tight/Cramping ***** = Tender/Sharp/Stabbing **^^^** = Burning

/// = Numb/Pins & Needles **#** = Itchy **C** = Cold **H** = Hot **W** = Weak **?** = Other

2) Indicate which areas are the worst in severity.

3) Make notes as necessary.



Review of Systems

Head (Other: _____)								
Headaches	Y	N	P		Migraines	Y	N	P
Fainting	Y	N	P		TMJ/Jaw Pain	Y	N	P
Facial Pain	Y	N	P		Lightheadedness	Y	N	P
Heaviness in the head	Y	N	P		Dizziness	Y	N	P
Eyes (Other: _____)								
Glasses/Contacts	Y	N	P		Poor Vision	Y	N	P
Night Blindness	Y	N	P		Color Blindness	Y	N	P
Eye Pain	Y	N	P		Blurry Vision	Y	N	P
Visual Spots/Floaters	Y	N	P		Dry eyes	Y	N	P
Cataracts	Y	N	P		Excess tearing	Y	N	P
Sensitive to light	Y	N	P		Double vision	Y	N	P
Ears (Other: _____)								
Ear aches/pain	Y	N	P		Tinnitus/Ringing	Y	N	P
Ear discharge	Y	N	P		Poor Hearing	Y	N	P
Nose/Sinuses (Other: _____)								
Stuck sensation in throat	Y	N	P		Congestion/blocked sinuses	Y	N	P
Nose bleeds	Y	N	P		Loss of smell	Y	N	P
Nasal Discharge	Y	N	P		Chronic sneezing	Y	N	P
Mouth/Throat (Other: _____)								
Poor dental health	Y	N	P		Bleeding Gums	Y	N	P
Teeth pain	Y	N	P		Teeth grinding	Y	N	P
Lumps/Swollen Glands	Y	N	P		Tonsillitis	Y	N	P
Recurrent sore throat	Y	N	P		Mouth/Tongue/Lip Sores	Y	N	P
Dry Lips	Y	N	P		Dry/hoarse throat	Y	N	P
Difficulty Swallowing	Y	N	P		Unusual taste in mouth	Y	N	P
Lungs (Other: _____)								
Chronic cough	Y	N	P		Shortness of breath lying down	Y	N	P
Pain with breathing	Y	N	P		Shortness of breath at night	Y	N	P

Review of Systems									
Wheezing	Y	N	P		Difficulty taking a deep breath	Y	N	P	
Frequent sighing	Y	N	P		Tuberculosis	Y	N	P	
Bronchitis	Y	N	P		Pneumonia	Y	N	P	
Clear sputum	Y	N	P		Emphysema	Y	N	P	
Colored sputum	Y	N	P		Allergies/Hayfever	Y	N	P	
Excess phlegm	Y	N	P		Asthma	Y	N	P	
Spitting up blood	Y	N	P		Weak voice/fatigued from talking	Y	N	P	
Heart/Circulation (Other: _____)									
Angina/Chest pain	Y	N	P		Heart murmur	Y	N	P	
Arrhythmia	Y	N	P		Fainting	Y	N	P	
Heart disease	Y	N	P		Bleeding/clotting disorder	Y	N	P	
High Blood Pressure	Y	N	P		Low Blood Pressure	Y	N	P	
Fast heart rate	Y	N	P		Slow Heart Rate	Y	N	P	
Irregular heart rate	Y	N	P		Palpitations	Y	N	P	
Heart attack	Y	N	P		Stroke	Y	N	P	
Heart valve dysfunction	Y	N	P		Anemia	Y	N	P	
Varicose Veins	Y	N	P		Spider Veins	Y	N	P	
Reynaud's disease	Y	N	P		Easy bruising	Y	N	P	
Cold hands/feet	Y	N	P		Calf Cramps	Y	N	P	
Swelling in the legs/ankle/feet	Y	N	P						
Abdomen/Digestion (Other: _____)									
No appetite	Y	N	P		Excessive hunger	Y	N	P	
Frequent nausea/vomiting	Y	N	P		Frequent hiccups	Y	N	P	
Heartburn/acid reflux	Y	N	P		Frequent belching	Y	N	P	
Stomach ulcers	Y	N	P		Frequent gas/bloating	Y	N	P	
Bad breath	Y	N	P		Hemorrhoids/anal fissures	Y	N	P	
Frequent rumbling in the intestines	Y	N	P		Diabetes	Y	N	P	
Gallbladder stones/GB disease	Y	N	P		Liver disease	Y	N	P	
Abdominal pain/cramping	Y	N	P		Hernia (type: _____)	Y	N	P	

Review of Systems									
Easy/sudden weight gain	Y	N	P		Easy/sudden weight loss	Y	N	P	
Eating disorder	Y	N	P		Parasites	Y	N	P	
Stool (Other: _____)									
How many bowel movements a day do you have?									
Diarrhea	Y	N	P		Constipation	Y	N	P	
Incomplete bowel movements	Y	N	P		Small pellet-like stool	Y	N	P	
Soft/loose stool	Y	N	P		Hard to pass	Y	N	P	
Watery stool	Y	N	P		Painful to pass	Y	N	P	
Black stool	Y	N	P		Urgent/cannot hold	Y	N	P	
Light colored/gray stool	Y	N	P		Bloody stool	Y	N	P	
Yellow/green stool	Y	N	P		Mucus in stool	Y	N	P	
Very strong smelling	Y	N	P		Undigested food in stool	Y	N	P	
Bladder/Kidney (Other: _____)									
Frequent urination (>6x/day)	Y	N	P		Infrequent urinary (<3x/day)	Y	N	P	
Heavy/strong flow	Y	N	P		Light/dribbling flow	Y	N	P	
Uncontrolled flow/incontinence	Y	N	P		Inability to empty bladder	Y	N	P	
Urgent/cannot hold	Y	N	P		Dark yellow	Y	N	P	
Very strong smelling	Y	N	P		Light yellow/clear	Y	N	P	
Pain with urination	Y	N	P		Cloudy or bubbly urine	Y	N	P	
Frequent urinary tract infections	Y	N	P		Blood in urine	Y	N	P	
Kidney stones	Y	N	P		Wake up to urinate (frequency: _____)	Y	N	P	
Kidney disease	Y	N	P						
Skin/Hair/Nails (Other: _____)									
Rashes	Y	N	P		Eczema/hives	Y	N	P	
Acne	Y	N	P		Psoriasis	Y	N	P	
Boils	Y	N	P		Warts	Y	N	P	
Skin ulcers	Y	N	P		Lumps	Y	N	P	
Itching	Y	N	P		Red skin	Y	N	P	
Discolored skin	Y	N	P		Moles removed	Y	N	P	

Review of Systems								
Dry skin	Y	N	P		Early graying/white hair	Y	N	P
Hair loss	Y	N	P		Dandruff/dry scalp	Y	N	P
Excess hair	Y	N	P		No sweating	Y	N	P
Spontaneous sweating	Y	N	P		Night sweating	Y	N	P
Unusual sweating in specific areas	Y	N	P		Frequent hangnails	Y	N	P
Malodorous sweat	Y	N	P		Ridged nails	Y	N	P
Brittle nails	Y	N	P		Nail biting	Y	N	P
Mental/Emotional (Other: _____)								
Unstable moods/mood swings	Y	N	P		Anxious	Y	N	P
Nervous	Y	N	P		Depression	Y	N	P
Fearful	Y	N	P		Withdrawn/Isolated	Y	N	P
Easily startled	Y	N	P		Despair/Suicidal	Y	N	P
Quick temper	Y	N	P		Grief/sorrow	Y	N	P
Irritable	Y	N	P		Indifferent/flat	Y	N	P
Tense/stressed	Y	N	P		Obsessive compulsive	Y	N	P
Poor impulse control	Y	N	P		Restless	Y	N	P
Poor memory/memory loss	Y	N	P		Worry/can't stop thinking	Y	N	P
Poor focus/difficulty concentrating	Y	N	P		Low drive/motivation/mental energy	Y	N	P
Cry easily	Y	N	P		Overly sensitive to other's emotions	Y	N	P
Sleep (Other: _____)								
Sleeping position: _____								
Difficulty falling asleep	Y	N	P		Restless sleep/tossing and turning	Y	N	P
Difficulty staying asleep	Y	N	P		Excessive/vivid dreaming	Y	N	P
Easily woken	Y	N	P		Nightmares	Y	N	P
Difficulty awakening	Y	N	P		Sudden wakening at a specific time	Y	N	P
Apnea	Y	N	P		Snoring	Y	N	P
Endocrine/Energy/Immunity (Other: _____)								
Always cold/intolerance to cold	Y	N	P		Always hot/intolerance to heat	Y	N	P
Sensation of heat in hands and feet	Y	N	P		Hot flashes	Y	N	P

Review of Systems								
Hypothyroid	Y	N	P		Hyperthyroid	Y	N	P
Excessive hunger	Y	N	P		Excessive thirst	Y	N	P
Persistent fatigue	Y	N	P		Easily fatigued with light exertion	Y	N	P
Adrenal condition	Y	N	P		Excess energy/can't settle down	Y	N	P
Persistent low grade fever	Y	N	P		Aversion to wind/drafts/air conditioning	Y	N	P
Swollen or painful lymph nodes	Y	N	P		Easily chilled	Y	N	P
Slow wound healing	Y	N	P		Easily catch colds/flu	Y	N	P
Chronic infections	Y	N	P		Goiter	Y	N	P
Male Reproductive (Other: _____)								
Prostate problem	Y	N	P		Testicular masses	Y	N	P
Erectile dysfunction	Y	N	P		Testicular pain	Y	N	P
Premature ejaculation	Y	N	P		Low libido	Y	N	P
Discharge	Y	N	P		Excessive libido	Y	N	P
Sores	Y	N	P		Venereal disease	Y	N	P
Fertility issues	Y	N	P					
Female Reproductive								
Age of first menses:					Age at menopause:			
Number of pregnancies:					Number of live births:			
Length of cycle:					Number of premature births:			
Duration of menses:					When was your last annual exam?			
Do you use birth control? What kind?					Do you do self-breast exams?			
Painful menses	Y	N	P		Endometriosis	Y	N	P
Heavy flow	Y	N	P		Ovarian cysts	Y	N	P
Large clots	Y	N	P		Cervical dysplasia	Y	N	P
Breast tenderness	Y	N	P		Midcycle bleeding	Y	N	P
PMS	Y	N	P		Peri/Menopausal symptoms	Y	N	P
Low libido	Y	N	P		Breast lumps	Y	N	P
Excessive libido	Y	N	P		Nipple discharge	Y	N	P
Fertility issues	Y	N	P		Lactation problem	Y	N	P

***

Comments: (Is there anything else about your health you would like to discuss?)

I feel that I have answered the above questions to the best of my ability and understand that if I choose to omit any health information I do so at my own risk and that in no way will the healthcare provider be held responsible for any omitted information. I will notify my healthcare practitioner of any changes in my health status.

_____ _____

Patient Signature (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date