



BERKELEY ACUPUNCTURE PROJECT

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Health Questionnaire and Registration

PATIENT INFORMATION	CONTACT INFORMATION
Date _____	Home phone _____
Name _____	Work phone _____
Address _____	Other/cell phone _____
City State Zip _____	Email _____
Age _____ Birthdate _____	Best way/time to reach you _____
Occupation _____	Another person we may contact if needed:
Company name _____	Name _____
Primary physician _____	Relationship _____
Physician phone number _____	Home phone _____
How did you hear about us? _____	Work phone _____

HEALTH HISTORY	
What are your primary concerns for coming in for treatment? 1- _____ 2 - _____ 3 - _____	Indicate symptoms you have or have had in the last year and include severity (1= <i>mild</i> ; 5= <i>severe</i>):
How is your sleep? _____	Depression 1 2 3 4 5
How is your digestion? _____	Difficulty in focusing 1 2 3 4 5
List medications or supplements you are taking: _____ _____	Dizziness 1 2 3 4 5
List serious illnesses, accidents or surgeries. _____ _____	Easily startled 1 2 3 4 5
Check illnesses that have occurred in blood relatives. <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Kidney disease	Excessive worry 1 2 3 4 5
How long has it been since you have had a complete medical exam? _____	Excessive anger 1 2 3 4 5
	Excessive fear 1 2 3 4 5
	Fatigue/tiredness 1 2 3 4 5
	Headaches 1 2 3 4 5
	Loss of sleep/poor sleep 1 2 3 4 5
	Loss or gain of weight 1 2 3 4 5
	Nervousness/irritability 1 2 3 4 5
	Overwhelmed by life 1 2 3 4 5
	Check conditions you have or have had in the past:
	<input type="checkbox"/> AIDS
	<input type="checkbox"/> Allergies
	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Arthritis
	<input type="checkbox"/> Bleeding disorders
	<input type="checkbox"/> Breast lump
	<input type="checkbox"/> Cancer
	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Hepatitis

HEALTH HISTORY...continued

Check symptoms you have or have had recently and please indicate severity level (1=mild; 5= severe):

MUSCLE/JOINT/BONES

Tremors	1	2	3	4	5
Cramps	1	2	3	4	5
Swollen joints	1	2	3	4	5
Pain, weakness, numbness in:					
Arms / Hands	1	2	3	4	5
Back / Hips	1	2	3	4	5
Legs / Feet	1	2	3	4	5
Neck / Shoulders	1	2	3	4	5
Other _____	1	2	3	4	5
_____	1	2	3	4	5

EYES/EAR/NOSE/THROAT/RESPIRATORY

Asthma/wheezing	1	2	3	4	5
Blurred or failing vision	1	2	3	4	5
Difficulty breathing	1	2	3	4	5
Earache	1	2	3	4	5
Enlarged glands	1	2	3	4	5
Eye pain	1	2	3	4	5
Frequent colds	1	2	3	4	5
Hay fever	1	2	3	4	5
Hoarseness	1	2	3	4	5
Gum trouble	1	2	3	4	5
Nose bleeds	1	2	3	4	5
Loss of hearing	1	2	3	4	5
Persistent cough	1	2	3	4	5
Ringing in ears	1	2	3	4	5
Sinus problems	1	2	3	4	5

SKIN

Boils	1	2	3	4	5
Bruise easily	1	2	3	4	5
Dry skin	1	2	3	4	5
Itching/rash	1	2	3	4	5
Sensitive skin	1	2	3	4	5
Sore won't heal	1	2	3	4	5
Sweats	1	2	3	4	5

GENITO/URINARY

Blood/pus in urine	1	2	3	4	5
Frequent urination	1	2	3	4	5
Inability to control urine	1	2	3	4	5
Kidney infection/stones	1	2	3	4	5

CARDIOVASCULAR

Chest pain	1	2	3	4	5
Hardening of arteries	1	2	3	4	5
High or low blood pressure	1	2	3	4	5
Pain over heart	1	2	3	4	5
Poor circulation	1	2	3	4	5
Previous heart attack? _____					
Rapid/irregular heart beat	1	2	3	4	5
Swelling of ankles	1	2	3	4	5

GASTROINTESTINAL

Belching, gas or bloating	1	2	3	4	5
Colon trouble	1	2	3	4	5
Constipation	1	2	3	4	5
Diarrhea/Loose Stools	1	2	3	4	5
Difficulty swallowing	1	2	3	4	5
Distention of abdomen	1	2	3	4	5
Excessive hunger	1	2	3	4	5
Gall bladder trouble	1	2	3	4	5
Hemorrhoids	1	2	3	4	5
Indigestion	1	2	3	4	5
Nausea	1	2	3	4	5
Pain over stomach	1	2	3	4	5
Poor Appetite	1	2	3	4	5
Vomiting	1	2	3	4	5

SEXUAL HEALTH & HORMONES:

Lowered libido	1	2	3	4	5
Erection difficulties	1	2	3	4	5
Penis discharge	1	2	3	4	5
Prostate trouble	1	2	3	4	5
Post Menopause since _____					
Bleeding between periods	1	2	3	4	5
Clots in menses	1	2	3	4	5
Excessive menstrual flow	1	2	3	4	5
Extreme menstrual pain	1	2	3	4	5
Irregular cycle	1	2	3	4	5
Menopausal symptoms	1	2	3	4	5
PMS symptoms	1	2	3	4	5
Scanty menstrual flow	1	2	3	4	5
Previous miscarriage _____					
Might you be pregnant? _____					

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____