WELLNESS HISTORY

Patient's Name: _____ Date _____

1) Have you ever been to Acupuncturist? ❑ Yes ❑ No

If Yes: ❑ Currently ❑ In the past, When: _____ Did it help? _____
What treatment did you receive? _____
If No: What have you heard: ❑ It helps ❑ It hurts ❑ Expensive ❑ It feels good
❑ Not real doctors ❑ You have to keep on going forever ❑ It helps only temporarily
❑ Other_____

2) Please check any or the following symptoms you have experienced in the last 6 months:

❑ Headaches/Migraines	❑ Elbow/Wrist/Hand pain	❑ Herniated /Degenerated Disc
❑ Dizziness / Vertigo	❑ Carpal Tunnel Syndrome	❑ Restless Leg Syndrome
❑ Neck pain	❑ Tingling/Numbness	❑ Fibromyalgia
❑ Mid back pain	❑ Lower back pain	❑ Arthritis/Osteoarthritis
❑ Arm/ Shoulder pain	❑ Sciatica (pain in leg)	❑ Stenosis (nerve canal narrowing)
❑ Sinus/Allergies	❑ Hip/Leg pain	❑ Chronic Fatigue / Tiredness
❑ Insomnia	❑ Knee/Ankle/Foot pain	❑ Tremor disorder
❑ Balance Problems	❑ Scoliosis (curved spine)	❑ Digestive problems
❑ High Blood Pressure	❑ Ringing in ear	❑ Whiplash
❑ Diabetes (high blood sugar)		Females: ❑ Infertility / Menstrual problems
❑ High Cholesterol	❑Other_____	

A) **Which of the above is the worst?** _____

How long have you had this condition? _____

How often do you get it? _____

How long does it last when you have it? _____

Where is it located exactly? _____

What type of pain is it? ❑ Sharp ❑ Dull ❑ Burning ❑ Aching ❑ Other _____
❑ Does it radiate or travel anywhere?_____

Is this problem: ❑ Getting worse ❑ Staying the same ❑ Getting better-please explain
_____

Describe how this condition feels at its worst _____

What kinds of activities make this problem worse? (sitting, standing, sports, hobbies)
_____

Is there anything that temporarily helps this condition? _____

Do you feel this condition will go away on its own and not return? ❑ Yes ❑ No

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B) **Which of the above conditions is the *next* worst?** _____

How long have you had this condition? _____

How often do you get it? _____

How long does it last when you have it? _____

Where is it located exactly? _____

What type of pain is it? ❑ Sharp ❑ Dull ❑ Burning ❑ Aching ❑ Other _____
❑ Does it radiate or travel anywhere?_____

Is this problem: ❑ Getting worse ❑ Staying the same ❑ Getting better-please explain

_____

Describe how this condition feels at its worst _____

What kinds of activities make this problem worse? (sitting, standing, sports, hobbies)

_____

Is there anything that temporarily helps this condition? _____

Do you feel this condition will go away on its own and not return? ❑ Yes ❑ No

3) Since the time you began suffering from these problems, what have you tried to do to get rid of them that has not worked permanently?

❑ Prescription Medications: Results_____
❑ Injections: Results _____
❑ Over-the-counter Medications: Results_____
❑ Massage: Results _____
❑ Exercise: Results_____
❑ Physical Therapy: Results _____
❑ Acupuncture: Results _____
❑ Home remedies: Please explain _____
❑ Other: Please explain _____

4) Describe how the above condition(s) affect you when they are at their worst:

❑ Moody ❑ Irritable ❑ Lose patience with others ❑ Less fun to be with
❑ Help less around the house ❑ Feel Nauseous ❑ Restricted in motion
❑ Have to lie down ❑ Don't want to do anything ❑ Other _____
❑ Interrupts sleep - Explain_____
❑ Restricts daily activities- Explain_____

_____

❑ Hinders recreational activities-Explain _____
❑ They have no affect on me

5) Is there anything else that these problems are preventing you from doing, either totally

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or partially, that you would really like to be doing again? ❑ Yes ❑ No
Please explain: _____
_____

6) What is your current occupation or past occupation (if retired)? _____
What type of work is involved mostly? (lifting, sitting, standing, etc) _____
_____

7) Are you less productive on your job because of these health problems? ❑ Yes ❑ No
Do you enjoy your work less because of these problems? ❑ Yes ❑ No
Do you have to take more breaks? ❑ Yes ❑ No

8) Healing occurs when you are asleep and sleep is essential to a proper immune system. Having problems with sleep is a complicating factor, which makes healing more difficult.
Do you have: 1) Trouble falling asleep due to being uncomfortable? ❑ Yes ❑ No
2) Not enough restful sleep? ❑ Yes ❑ No
3) Awaken in the middle of the night? ❑ Yes ❑ No
4) Waking earlier than you normally would? ❑ Yes ❑ No

9) When was the last time you woke up feeling good? _____

10) Is this problem negatively impacting your relationships with your loved ones, friends, colleagues, or others? ❑ Yes ❑ No

11) Have you had to just learn to live with these problems? ❑ Yes ❑ No

12) Do you feel the quality of your life has decreased as a result of these problems? ❑ Yes ❑ No

13) If these problems are left untreated, do you feel they will get worse? ❑ Yes ❑ No
How do you feel that would affect you? _____
_____
(develop arthritis? become bedridden? or become unable to function normally?, etc.)

14) Comparing your health now to 5-10 years ago, do you feel your overall health is:

❑ Improving ❑ Getting Worse ❑ Staying the Same

15) What would life be like if you got these problems corrected and they didn't return?

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_____

_____

16) Would you feel younger if you didn't have these problems? ❑ Yes ❑ No

How many years younger would you feel? _____

17) We believe that a person's health is more important than anything else.
Without your health, you can't enjoy life. No matter how much money or material possessions a person has, they would always want their health first.

Do you agree that your health should be your top priority? ❑ Yes ❑ No

18) Do you feel it's time to do something about this problem?

❑ Yes ❑ No

19) On a scale of 1 to 10, 10 being the most committed and 1 being the least committed, please rate your commitment to getting your health problems handled:

Please circle one: (low priority) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (top priority)

20) Please check off which tests you have had in the past:

❑ MRI ❑ neck – when _____ ❑ low back – when _____
❑ CT SCAN ❑ neck – when _____ ❑ low back – when _____
❑ X-RAYS ❑ neck – when _____ ❑ low back – when _____
For X-rays: Were they taken: ❑ Standing ❑ Seated or ❑ Lying down
❑ Other: _____ when _____ ❑ Other: _____ when _____

PLEASE FILL OUT NEXT PAGE

Check off any of the following symptoms you currently have or recently had:

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CONDITION	Frequency	CONDITION	Frequency
❑ ADD/ADHD - learning problems		❑ Heart Murmur	
❑ Allergies		❑ Hemorrhoids	
❑ Allergies - Food		❑ High Cholesterol	
❑ Anemia		❑ Hypersomnia (sleeping too much)	
❑ **Aneurysm**		❑ Hypoglycemia (low blood sugar)	
❑ Arteriosclerosis – Hardening of the Arteries		❑ Infertility / Uterine problems / Miscarriages	
❑ Arthritis / Joint pain / DJD / Osteoarthritis		❑ Insomnia	
❑ Asthma / Emphysema		❑ Irregular Heart Rate	
❑ Auto-Immune Disease		❑ Joint Cramps / Pain	
❑ Bed wetting		❑ Kidney Problems	
❑ Bladder / Urination Problems		❑ Libido Decreased	
❑ Bloating		❑ Liver problems	
❑ Blood Pressure-high / low		❑ Low Resistance to Infections	
❑ Bronchitis / cough / Breathing problems		❑ Male = Prostate problem / Impotence	
❑ **Cancer**		❑ Memory Loss (loss of concentration)	
❑ Candida Albicans / Yeast Infections		❑ Menopause / Hot flashes	
❑ Chest Pain / Pneumonia		❑ Numbness / Tingling	
❑ Colds (chronic) / sore throat / Tonsillitis		❑ **Osteoporosis / Osteopenia**	
❑ Constipation		❑ Over / Under Weight	
❑ Depression		❑ PMS / Menstrual problems / cramps	
❑ Diabetes (high blood sugar)		❑ Poor Circulation / Cold hands or feet	
❑ Diarrhea / Digestive Problems / Colitis / Gas		❑ Psoriasis	
❑ Dizziness / Vertigo / Imbalance / Falling		❑ Rapid Heart Rate	
❑ Ear Infections / Earaches		❑ Seizures	
❑ Eye Trouble / Vision difficulty		❑ Shingles	
❑ Edema / water retention (swelling feet)		❑ Shortness of Breath	
❑ Epilepsy		❑ Sinus Problems	
❑ Failed Back/ Neck/ Wrist Surgery		❑ Skin Disorders / Eczema / Hives / Acne	
❑ Fainting Spells		❑ Stiffness	
❑ Fatigue / Exhaustion / Low energy		❑ Stomach Problems / Nausea / Indigestion	
❑ Fibromyalgia		❑ Thyroid Disorder	
❑ Gall bladder problems		❑ TMJ	
❑ Headaches (non-migraine)		❑ Ulcer	
❑ Headaches - Migraine		❑ Varicose veins	
❑ Hearing problems		❑ Weakness or cramps in legs	
❑ Heart Disease – Cardiovascular Disease		❑ Weight gain / loss	

Please list any other complaints or concerns here that you wish you could get rid of, even if you wouldn't necessarily think that it's something we could help you with: _____

What Prescribed Medications are you currently taking?

_____
_____
_____
_____

What Over-The-Counter Medications are you taking?

_____

What Supplements are you taking? _____

_____
_____

Do you have a pacemaker? ❑ Yes ❑ No

Do you have a history of:

❑ Cancer? Date_____

❑ Gall Stones? Date_____

❑ Heart Attack? Date_____

❑ Stroke? Date_____

❑ Surgery? -For_____

Date_____

-For _____

Date_____

❑ Other_____

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1) Do you take various vitamins, minerals, herbs or homeopathic remedies without being absolutely sure what really you need? ❒ Yes ❒ No

2) Have you ever been tested to find out what vitamins or minerals you *really* need? ❒ Yes ❒ No

3) Did you know that taking vitamins, minerals or herbs taken ***randomly*** can cause Nutritional Deficiencies? ❒ Yes ❒ No

4) Do you have trouble losing weight or keeping it off? ❒ Yes ❒ No

5) Do you eat less than you used to but still can't lose weight? ❒ Yes ❒ No

6) Would you like to know if your metabolism has slowed down, causing lack of energy, weight gain or trouble losing weight? ❒ Yes ❒ No

7) Would you like to find out how to slow down your aging process *naturally* from the inside out? ❒ Yes ❒ No

8) Would you like to find out if underlying Nutritional Deficiencies or Imbalances are causing ***any*** health problems? ❒ Yes ❒ No

9) Would you like to find out what are the best foods for YOU based on testing? ❒ Yes ❒ No

10) Would you like to watch the video that explains the program to find the answers to these questions? ❒ Yes ❒ No