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Acupuncture POINTS

Your Way to Health

Licensed Acupuncturist
IL #198-000085
Yosef Pollack

PATIENT HEALTH APPRAISAL

~ Strictly confidential ~

Name _____ Age ___ Date of birth ___/___/___ Relationship status _____
 Address _____ Birthplace _____ Number of Children _____
 City _____ State ___ Zip _____ Referred to us by _____
 Phone: (mobile) _____ (work) _____ (home) _____
 e-mail: _____ Occupation _____ # work hrs/wk _____
 Emergency Contact: _____ Relationship _____ Phone _____
 Physicians name: _____ Phone: _____
 May I contact your physician to discuss your condition? ___Yes ___ No Your Health Ins Co? _____
 Note: All patients pay as they go. Refer to our "INSURANCE" page for reimbursement and other options to help defray out of pocket expenses.

HEIGHT: ___ ft. ___ in. WEIGHT: _____ pounds BLOOD PRESSURE: ___high ___low ___normal WTP_

Why have you come for acupuncture treatment?

New/Acute problems:

Old/Chronic problems:

Treatments to date:

Current medications (taken within last 2 months):

Current "natural" remedies/supplements:

What do you do for exercise?

Major Stresses in life:

PERSONAL HEALTH HISTORY

Hospitalizations:	Medicinal allergies:
Surgeries:	Environmental allergies:
Injuries//traumas:	Food allergies:
Broken bones:	Catch cold or virus easily?
Scars/stitches:	Frequent sore throat?

Childhood Illness <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> German Measles <input type="checkbox"/> Scarlet Fever	Immunizations <input type="checkbox"/> DPT <input type="checkbox"/> Tetanus Booster <input type="checkbox"/> Measles/Mumps/Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Influenza	Exposures <input type="checkbox"/> Hepatitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes <input type="checkbox"/> HIV exposure <input type="checkbox"/> tested positive <input type="checkbox"/> tested negative	Implants/Prostheses <input type="checkbox"/> Breast implant (s) <input type="checkbox"/> Pace Maker <input type="checkbox"/> other (describe)
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USE OF

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> alcohol | <input type="checkbox"/> cocaine |
| <input type="checkbox"/> tobacco | <input type="checkbox"/> marijuana |
| <input type="checkbox"/> caffeine | <input type="checkbox"/> Heroin |
| <input type="checkbox"/> sugar | <input type="checkbox"/> valium |
| other drugs (describe) | |

FAMILY HEALTH AND GENETIC HISTORY

i.e. Diabetes, Cancer, Parkinson's...

Mother:	Maternal Grandparents:
Father:	Paternal Grandparents:
Sisters/Brothers:	Children:

"GENERAL BODY CHECK" DO YOU HAVE PROBLEMS WITH ANY OF THESE?

PAIN (WHERE) <input type="checkbox"/> sharp/stabbing: <input type="checkbox"/> dull/aches: <input type="checkbox"/> localized: <input type="checkbox"/> crampish: <input type="checkbox"/> moving/tingling:		CIRCULATION: <input type="checkbox"/> numbness <input type="checkbox"/> cold areas <input type="checkbox"/> Reynaud's disease <input type="checkbox"/> hot areas <input type="checkbox"/> bruise easily		<input type="checkbox"/> varicosity <input type="checkbox"/> phlebitis <input type="checkbox"/> postural hypotension (feel faint if you stand quickly or too long)		HEADACHES (DESCRIBE) <input type="checkbox"/> Migraine <input type="checkbox"/> Cluster headaches w/Allergies <input type="checkbox"/> Headaches with nausea <input type="checkbox"/> Frontal <input type="checkbox"/> Temples <input type="checkbox"/> Occipital - base of skull							
MENTAL/NEUROLOGIC <input type="checkbox"/> slow thinking <input type="checkbox"/> fast thinking <input type="checkbox"/> forgetful <input type="checkbox"/> lack concentration <input type="checkbox"/> vertigo <input type="checkbox"/> seizures		EMOTIONAL PROBLEMS <input type="checkbox"/> depression <input type="checkbox"/> anxiety-heart palpitations <input type="checkbox"/> panic attacks <input type="checkbox"/> phobias <input type="checkbox"/> mania stress <input type="checkbox"/> irritable/angry		EYES <input type="checkbox"/> vision problems <input type="checkbox"/> blurry vision <input type="checkbox"/> photosensitivity <input type="checkbox"/> infections <input type="checkbox"/> dryness <input type="checkbox"/> redness <input type="checkbox"/> pain behind eyes		EARS <input type="checkbox"/> hearing loss <input type="checkbox"/> tinnitus <input type="checkbox"/> frequent infections <input type="checkbox"/> clogged <input type="checkbox"/> popping		NOSE <input type="checkbox"/> sinus infections <input type="checkbox"/> sinusitis <input type="checkbox"/> postnasal drip <input type="checkbox"/> deviated septum <input type="checkbox"/> loss of smell <input type="checkbox"/> bleeding <input type="checkbox"/> allergy/sniffles					
SKIN <input type="checkbox"/> acne <input type="checkbox"/> itching <input type="checkbox"/> eczema		<input type="checkbox"/> hives <input type="checkbox"/> rashes		HAIR <input type="checkbox"/> dryness <input type="checkbox"/> alopecia <input type="checkbox"/> premature graying		<input type="checkbox"/> hair loss		NAILS (FINGERS/TOES) <input type="checkbox"/> dry <input type="checkbox"/> brittle <input type="checkbox"/> cracks/splits		<input type="checkbox"/> discolored <input type="checkbox"/> infected <input type="checkbox"/> ingrown		TONGUE <input type="checkbox"/> peeling areas <input type="checkbox"/> sores/blisters <input type="checkbox"/> sensitivity	
MOUTH <input type="checkbox"/> lips chapped <input type="checkbox"/> cold sores <input type="checkbox"/> bleeding gums <input type="checkbox"/> periodontitis <input type="checkbox"/> lots of cavities <input type="checkbox"/> silver fillings <input type="checkbox"/> teeth loose <input type="checkbox"/> teeth hurt/ache <input type="checkbox"/> without cavities <input type="checkbox"/> Temporo-Mandibular <input type="checkbox"/> Joint (TMJ) problems		THROAT <input type="checkbox"/> dry <input type="checkbox"/> itchy <input type="checkbox"/> sore <input type="checkbox"/> hot <input type="checkbox"/> excess mucus <input type="checkbox"/> swollen glands <input type="checkbox"/> tight <input type="checkbox"/> thyroid		VOICE <input type="checkbox"/> hoarseness <input type="checkbox"/> stuttering		BLOOD TESTS WITH IRREGULAR RESULTS: <input type="checkbox"/> high cholesterol <input type="checkbox"/> hyperthyroid (high) <input type="checkbox"/> hypothyroid (low) <input type="checkbox"/> diabetes <input type="checkbox"/> high blood sugar <input type="checkbox"/> hypoglycemic <input type="checkbox"/> low blood sugar <input type="checkbox"/> anemia <input type="checkbox"/> Candida/yeast		AUTONOMIC NERVOUS SYSTEM <input type="checkbox"/> low blood pressure <input type="checkbox"/> high blood pressure <input type="checkbox"/> cold hands/feet <input type="checkbox"/> night sweats <input type="checkbox"/> sweat easily <input type="checkbox"/> particular areas: <input type="checkbox"/> never sweat <input type="checkbox"/> often hot <input type="checkbox"/> often cold <input type="checkbox"/> slow pulse (less than 60) <input type="checkbox"/> fast pulse (more than 100)					
HEART & LUNGS <input type="checkbox"/> asthma <input type="checkbox"/> shallow breathing <input type="checkbox"/> short of breath: <input type="checkbox"/> on exertion <input type="checkbox"/> at rest <input type="checkbox"/> when lying down <input type="checkbox"/> pressure on chest <input type="checkbox"/> cough <input type="checkbox"/> chronic bronchitis <input type="checkbox"/> phlegm/mucus <input type="checkbox"/> frequent colds <input type="checkbox"/> mitral valve prolapse <input type="checkbox"/> palpitations		DIGESTION CONT'D. <input type="checkbox"/> belching <input type="checkbox"/> rumbling sounds <input type="checkbox"/> heartburn <input type="checkbox"/> ulcer <input type="checkbox"/> lack of stomach acid <input type="checkbox"/> can't digest fats <input type="checkbox"/> hiccups <input type="checkbox"/> hiatal hernia <input type="checkbox"/> stomach problems <input type="checkbox"/> liver problems <input type="checkbox"/> spleen problems <input type="checkbox"/> gall bladder problems <input type="checkbox"/> pancreas problems <input type="checkbox"/> large intestine problems <input type="checkbox"/> sm. intestines problems <input type="checkbox"/> colitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> appendix <input type="checkbox"/> ileocecal valve <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> undigested food in stool		DIGESTION CONT'D. <input type="checkbox"/> blood in stool <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> hemorrhoids <input type="checkbox"/> itching <input type="checkbox"/> burning <input type="checkbox"/> bleeding <input type="checkbox"/> flatulence <input type="checkbox"/> hernia		URINATION <input type="checkbox"/> kidneys <input type="checkbox"/> adrenal <input type="checkbox"/> bladder <input type="checkbox"/> frequent urge to urinate <input type="checkbox"/> scanty urination <input type="checkbox"/> urinary tract infections <input type="checkbox"/> frequent <input type="checkbox"/> pain or discomfort <input type="checkbox"/> color of urine: <input type="checkbox"/> golden yellow <input type="checkbox"/> pale <input type="checkbox"/> deep yellow/orange <input type="checkbox"/> stones <input type="checkbox"/> strong odor		MUSCULO-SKELETAL <input type="checkbox"/> rheumatism <input type="checkbox"/> arthritis <input type="checkbox"/> connective tissue <input type="checkbox"/> ligament disease <input type="checkbox"/> lupus erythematosus <input type="checkbox"/> upper back/spine <input type="checkbox"/> mid back/spine <input type="checkbox"/> lumbar spine <input type="checkbox"/> whiplash <input type="checkbox"/> neck <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/> wrists <input type="checkbox"/> hands <input type="checkbox"/> fingers <input type="checkbox"/> rib cage <input type="checkbox"/> pelvis sacrum <input type="checkbox"/> coccyx <input type="checkbox"/> hips <input type="checkbox"/> knees <input type="checkbox"/> shins <input type="checkbox"/> ankles <input type="checkbox"/> feet <input type="checkbox"/> toes					

Please detail answers

DIET & FOOD PREFERENCES

DIET PATTERNS AND FOODS EATEN:

~ details please ~

- average appetite
- always hungry
- lack of appetites

- | | | |
|--------|--------------------------|--------------------------|
| | like | dislike |
| bitter | <input type="checkbox"/> | <input type="checkbox"/> |
| salty | <input type="checkbox"/> | <input type="checkbox"/> |
| sour | <input type="checkbox"/> | <input type="checkbox"/> |
| spicy | <input type="checkbox"/> | <input type="checkbox"/> |
| sweet | <input type="checkbox"/> | <input type="checkbox"/> |

I drink ounces of liquid each day

- I feel thirsty and drink a lot
- I feel thirsty and don't drink
- I prefer hot cold drinks

BREAKFAST:

LUNCH:

DINNER:

Amount
(hours per night)

- Quality:
- deep
 - restless
 - insomnia

SLEEP

- trouble falling asleep
- trouble getting back to sleep
- not refreshed upon waking

- Dreams:
- often
 - average
 - never

Please detail answers

WOMEN

date of last menstruation:

number of days in cycle:

amount of flow:

color:

odor:

cramping:

blood clots: yes ___ no ___

date of last Pap Smear ___/___

Number of pregnancies:

deliveries:

caesareans:

miscarriages:

abortions:

Birth control pills used?

No

Yes, how long:

Diaphragm / IUD

premenstrual syndrome

dysmenorrhea

amenorrhea

infertility

endometriosis

Pelvic Inflammatory Disease

fibroids

ovarian cysts

abnormal pap smear

cervical dysplasia

vaginal discharge

breast tenderness

breast discharge

Fibrocystic breast disease

menopause

peri-menopause

Sexual Energy (Qi) Interest: High Average Low

Sexually active: Yes No

MEN

Prostatitis Infertility Impotent:

Sexual Energy (Qi) Interest: High Average Low

Sexually active: Yes No

SUPPLEMENTS

While we often recommend supplements and herbs to our patients, you are under no obligation to purchase from us. We offer convenience, competitive prices and advice; however you may find better prices elsewhere. We encourage you to make the best decisions for yourself.

HEALTH INSURANCE

We are often asked, "Do you accept insurance?" The simple answer is "no". **However**, it may still be possible for you to be reimbursed by your insurance carrier for treatment. Fortunately, more and more insurance companies are now covering acupuncture treatment, but we still have a long way to go.

We have found that insurance companies are much more responsive to patients rather than providers. We will do whatever we can to help you receive reimbursement.

CANCELLATION POLICY

While we do understand that sometimes it can't be avoided, we reserve the right to a \$50 charge for acupuncture appointments cancelled or broken without 24 hours notice and the full fee for cancelled massage appointments without 24 hours notice.

Yes, I have read and fully comply with this Cancellation Policy

My Initials: _____