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# Acupuncture POINTS

Your way to Health

~ Strictly confidential ~



Licensed Acupuncturist  
IL #198-000085

**Yosef Pollack**

## Patient Health Appraisal

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: PATIENTS PAY AS THEY GO.** Read our "INSURANCE" page for reimbursement & other options to help defray out of pocket costs.

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...How long?:

Current Rx medications (taken in last 2 months):

Current "natural" remedies/supplements:

What is your exercise/workout?

Present living situation:

Major Stresses In Your Life:

### ~ Personal Health History ~

Hospitalizations:

Surgeries:

Injuries//traumas:

Broken bones:

Scars/stitches:

Medicinal allergies:

Environmental allergies:

Food allergies:

Catch cold or virus easily?

Frequent sore throat?

#### Childhood Illness

- Chicken Pox  
 Measles  
 Mumps  
 German Measles  
 Scarlet Fever

#### Immunizations

- DPT  
 Tetanus Booster  
 Measles/Mumps/Rubella  
 Hepatitis B  
 Influenza

#### Exposures

- Hepatitis  
 Tuberculosis  
 Herpes  
 COVID or HIV exposure  
 tested positive  tested negative

#### Implants/Prostheses

- Breast implant (s)  
 Pace Maker  
 other (describe)

#### Use of

- Alcohol  cocaine  
 Tobacco  marijuana  
 Caffeine  Heroin  
 Sugar  Opioids

#### Family Health and Genetic History

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

Mother:

Father:

Sisters/Brothers:

Maternal Grandparents:

Paternal Grandparents:

Children:

# "General Body Check" Do you have problems with any of these:

<b>PAIN ... is it</b> <input type="checkbox"/> sharp/stabbing: <input type="checkbox"/> dull/aches: <input type="checkbox"/> localized: <input type="checkbox"/> crampish: <input type="checkbox"/> moving/tingling:		<b>CIRCULATION:</b> <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)		<b>HEADACHES</b> <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					
<b>MENTAL/NEUROLOGIC</b> <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		<b>EMOTIONAL PROBLEMS</b> <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		<b>EYES</b> <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		<b>EARS</b> <input type="checkbox"/> hearing loss <input type="checkbox"/> tinnitus <input type="checkbox"/> frequent infections <input type="checkbox"/> clogged <input type="checkbox"/> popping		<b>NOSE</b> <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			
<b>SKIN</b> <input type="checkbox"/> acne <input type="checkbox"/> itching <input type="checkbox"/> eczema		<b>HAIR</b> <input type="checkbox"/> dryness <input type="checkbox"/> alopecia <input type="checkbox"/> premature graying		<b>NAILS (FINGERS/TOES)</b> <input type="checkbox"/> dry <input type="checkbox"/> brittle <input type="checkbox"/> cracks/		<input type="checkbox"/> hives <input type="checkbox"/> rashes		<input type="checkbox"/> hair loss <input type="checkbox"/> discolored <input type="checkbox"/> infected <input type="checkbox"/> ingrown		<b>TONGUE</b> <input type="checkbox"/> peeling areas <input type="checkbox"/> sores/blisters <input type="checkbox"/> sensitivity	
<b>MOUTH</b> <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 Joint (TMJ) problems		<b>THROAT</b> <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		<b>BLOOD TESTS WITH IRREGULAR RESULTS:</b> <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		<b>AUTONOMIC NERVOUS SYSTEM</b> <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)					
<b>HEART &amp; LUNGS</b> <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		<b>DIGESTION CONT'D.</b> <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		<b>DIGESTION CONT'D.</b> <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		<b>URINATION</b> <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 <b>color of urine:</b> <input type="checkbox"/> golden yellow <input type="checkbox"/> pale <input type="checkbox"/> deep yellow/orange <input type="checkbox"/> stones <input type="checkbox"/> strong odor		<b>MUSCULO-SKELETAL</b> <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"/> feet <input type="checkbox"/> ankles <input type="checkbox"/> toes			

~ Please detail answers ~

### Diet & Food Preferences

Diet patterns and foods eaten:  
~ details please ~

- |  |        |                          |                          |  |
|--|--------|--------------------------|--------------------------|--|
|  |        | like                     | dislike                  |  |
| <input type="checkbox"/> average appetite  | bitter | <input type="checkbox"/> | <input type="checkbox"/> | I drink <input type="text"/> ounces  |
| <input type="checkbox"/> always hungry     | salty  | <input type="checkbox"/> | <input type="checkbox"/> | of liquid each day   |
| <input type="checkbox"/> lack of appetites | sour   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> I feel thirsty and drink a lot                    |
|  | spicy  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> I feel thirsty and don't drink                    |
|  | sweet  | <input type="checkbox"/> | <input type="checkbox"/> | I prefer <input type="checkbox"/> hot <input type="checkbox"/> cold drinks |

breakfast:

lunch:

dinner:

### Sleep

Amount   
(hours per night)

- Quality:
- deep
  - restless
  - insomnia

- 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
- abnormal pap smear
- dysmenorrhea
- cervical dysplasia
- amenorrhea
- vaginal discharge
- infertility
- breast tenderness
- endometriosis
- breast discharge
- Pelvic Inflammatory Disease
- Fibrocystic breast disease
- fibroids
- menopause
- ovarian cysts
- 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** ~ "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

**TREATMENT PLAN OPTIONS** ~ Acupuncture Treatment Plans Save Time & Money. The goal is to "feel" better and to "correct" health issues so they don't return. This takes a short time or a longer time. For chronic conditions, most patients opt for Treatment Plans. Non-refundable payments are made in full. Treatments cannot be shared with others.

### ~ CANCELLATION POLICY ~

**YOU WILL BE CHARGED THE FULL AMOUNT FOR ACUPUNCTURE APPOINTMENTS IF WE ARE NOT GIVEN 24 HOURS NOTICE**

**You are responsible for payment prior to scheduling your next session.**

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

**My Initials: \_\_\_\_\_**