Tabares Active Health

Thank you for coming. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask. Thank you.

New Patient Information

Name _____Date_____

Sex □ F □ M Marital status _____ Date of Birth _____ Age_____ # of children _____

Main phone #_____ Other phone # _____

E-mail address _____ Allow email contact by *Tabares Active Health* □ Yes □ No

Address: Street _____City _____State _____ Zip _____

Emergency contact name & phone _____

Family physician/ chiropractor _____

Have you ever been treated by acupuncture before? _____

How did you find out about our clinic? *Whom may we thank for referring you?*_____

Health Concern(s) Please list your top three health concerns in order of priority.

1. _____
2. _____
3. _____

Treatment Goals: (Please Circle One) Maintenance Resolve Symptoms-Fix Cause Optimal-Health/ Wellness

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ What are the causes of this problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse? _____What makes this problem better? _____

Is there anybody in your family with the same/similar problems? _____ Remarks and additional information: _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: _____ **Hospitalization:** _____

Significant trauma: (auto accidents, sports injuries, etc.) _____

Allergies: (drugs, chemicals, foods, environmental) _____

_____

DIAGNOSIS	SELF	FAMILY	DIAGNOSIS	SELF	FAMILY
Alcoholism			**Fibromyalgia**		
Anemia			**Heart Stent or Pacemaker**		
Autoimmune Conditions			**Hepatitis**		
Breathing Problems			**High Blood Pressure**		
Cancer (what type)			**Seizures**		
Chronic Fatigue			**Thyroid Disease**		
Depression or Anxiety			**Tuberculosis**		
Digestive Disorders			**Venereal Disease** (STDs)		
Emotional Disorders			**Other**		

Medications taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

_____

Occupation : _____ Do you usually work □ indoors □ outdoors? Occupational stress (chemical, physical, psychological, etc): _____

Personal Height_____ Weight now_____ Weight one year ago_____ Weight maximum _____ @Year _____

Habits Do you smoke? □ Yes □ No What? _____ How many per day? _____ Since when? _____

Please describe any use of drugs for non-medical purposes:_____

Do you exercise regularly □ Yes □ No How many times a week? _____

How many hours do you sleep in general? _____ What time do you usually go to bed? _____

Are you healthier today than you were 5 years ago? □ Yes □ No Why?_____

Diet How much coffee do you drink? _____cups/day Colas _____number/day Tea _____ cups/day _____

What kind of alcoholic beverages do you usually drink, if any? _____ Average number of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? □ Yes □ No □ Yes, but not so strict. □ Pesco □ Lacto □ Ovo □ Vegan

Do you eat a lot of spicy food? □ Yes □ No Do you have any dietary restrictions? □ Yes □ No _____

Remarks and additional information (e.g. diet) _____

Please describe your average daily diet (Please be as specific as possible):

Morning _____

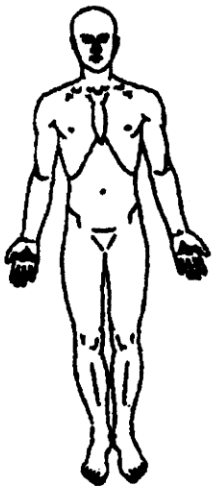
Afternoon _____

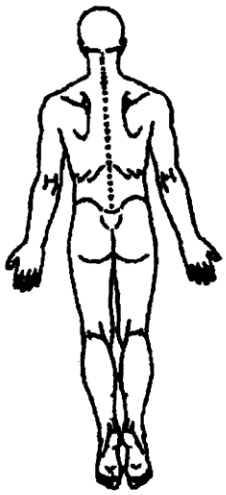
Evening _____

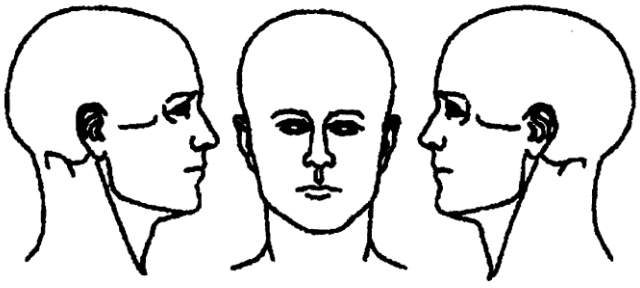
Snacks _____

Indicate pain or discomfort with:

Sharp • **Dull X** **Tingle :::** **Burn Δ** **Cramp +** **Numb =** **Cold O**







Please check if you have or have had (in the last three months) any of the following diseases or conditions:

General □ Poor appetite □ Poor sleep □ Fatigue □ Fevers □ Chills □ Night sweats □ Sweat easily □ Tremors □ Cravings □ Change in appetite □ Poor balance □ Bleed or bruise easily □ Localized weakness □ Weight loss □ Weight gain □ Peculiar tastes □ Desire hot food □ Desire cold food □ Strong thirst (cold or hot drinks) □ Sudden energy drop (What time of day) _____ Favorite time of year _____ Worst time of year _____

Skin & hair □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles □ Loss of hair □ Purpura □ Change in hair or skin texture □ Other? _____

Musculoskeletal □ Neck tightness □ Neck pain □ Shoulder pain □ Hand/wrist pain □ Elbow pain □ Back pain □ Hip pain □ Knee pain □ Pain/soreness in the muscles □ Muscle weakness □ Joint disorders □ Tremors □ Cold hands/feet □ Swelling of hands/feet □ Hernia □ Numbness □ Tingling □ Paralysis □ Joint Sprain □ Difficulty walking □ Spinal curvature: □ Cervical □ Thoracic □ Lumbar □ Other? _____

Head, eyes, ears, nose, and throat □ Dizziness □ Concussions □ Migraines □ Glasses/lens □ Eye strain □ Eye pain □ Color blindness □ Night blindness □ Poor vision □ Cataracts □ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing □ Spots in front of eyes □ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain □ Jaw clicks □ Sores on lips/tongue □ Difficulty swallowing □ Other? _____

Cardiovascular □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitations □ Fainting □ Phlebitis □ Irregular heartbeat □ Rapid heartbeat □ Varicose veins □ Other? _____

Respiratory □ Cough □ Coughing blood □ Shortness of Breath □ Wheezing □ Difficulty breathing □ Bronchitis □ Pneumonia □ Chest pain/ tightness/ congestion □ Production of phlegm – What color? _____

Gastrointestinal □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Bloating □ Belching □ Black stools □ Blood in stools □ Indigestion □ Bad breath □ Rectal pain □ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites □ Chronic laxative use Bowel movements: Frequency _____ Color _____ Odor _____ Texture/ Form _____

Neuro-psychological □ Loss of balance □ Lack of coordination □ Concussion □ Poor Memory short/ long term □ Poor Concentration □ Difficulty Making Decisions □ Speech problem □ Depression □ Anxiety □ Stress □ Short temper □ Mood Swings □ Bi-polar □ Other? _____

Genito-urinary □ Painful urination □ Frequent urination □ Blood in urine □ Urgency to urinate □ Kidney stones □ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection □ Genital pain □ Genital itching □ Genital rashes □ STD □ Other? _____

Female □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge □ Fibroids □ Ovarian cysts □ Regular periods □ Clots □ Pain/cramps prior/during periods □ Breast tenderness □ Breast Lumps □ Fertility Problems □ Hot flashes □ Moodiness related to periods □ Hysterectomy/ ovaries removed

First date of last period _____ Age of first period _____ Duration of periods _____days, cycle ____ days

Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions _____ Premature births _____

C-section _____ Difficult delivery_____

Do you practice birth control? □ Yes □ No. If yes, what type and for how long? _____

If you're on birth control pills, what are you taking and for how long? _____

Male □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems □ Frequent seminal emission □ Fertility problems □ Painful/swollen testicles □ Other _____

I have completed this form correctly to the best of my knowledge.

Signature: □ Adult Patient □ Parent or Guardian □ Spouse

_____

Signature **Date**

Are there any other health issues you want to discuss with us?