VIBRATIONAL HEALING ARTS

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The following is a confidential questionnaire to determine the best possible treatment plan for you. Please take your time in completing the information. THANK YOU !

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A. PERSONAL INFORMATION:

NAME: _____, _____, _____
LAST **FIRST** **MIDDLE**

ADDRESS: _____

_____ _____ _____
CITY **STATE** **ZIPCODE**

PHONE #: **HOME ( )** _____
WORK ( ) _____
e-mail address: _____

BIRTHDATE: _____

DRIVERS LICENSE #: _____, _____
STATE OF ISSUE

SOCIAL SECURITY #: _____

EMPLOYER: _____

MARRIAGE STATUS:
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW(ER)

IF MARRIED, PLEASE FILL OUT SPOUSE'S INFO:

NAME: _____ S.S.#: _____

EMPLOYER: _____

INSURANCE INFORMATION
INSURANCE COMPANY NAME: _____

ADDRESS: _____
PHONE #: _____ INSURER _____
GROUP #: _____ CLAIM #: _____

WHO REFERED YOU TO THIS OFFICE?
_____

HAVE YOU EVER BEEN TREATED BY AN ACUPUNCTURE DOCTOR BEFORE? ☐ **YES** ☐ **NO**
IF YES, PLEASE GIVE THE NAME OF THE DOCTOR.

_____

**** CONTINUE ON NEXT PAGE PLEASE ****

PAGE 2

B. MEDICAL HISTORY

HEIGHT: _____ WEIGHT: _____
WHEN WERE YOU LAST SEEN BY A PHYSICIAN: _____

REASON FOR THE VISIT: _____

NAME OF THE PHYSICIAN: _____ PHONE : _____

PLEASE INDICATE ANY HOSPITALIZATIONS YOU HAVE HAD:

1. _____
   DATE: _____
2. _____
   DATE: _____

PLEASE DESCRIBE THE REASON (S) FOR VISITING THIS OFFICE:

_____
_____

PLEASE INDICATE OTHER HEALTH PROBLEMS YOU HAVE, IF ANY.

_____
_____
_____

C. YOUR HEALTH INFORMATION

IS THERE A HISTORY OF CANCER, TUBERCULOSIS OR DIABETES, ETC. IN YOUR FAMILY?

☐ **YES** ☐ **NO** IF YES, **WHO:** **WHAT ILLNESS:**

_____, _____
_____, _____

PLEASE LIST ANY PRESCRIBED MEDICINE(S) THAT YOU ARE PRESENTLY TAKING?

MEDICINE:	**DOSAGE:**
_____	_____
_____	_____
_____	_____

HOW OFTEN DO YOU DRINK TEA, COFFEE OR ALCOHOL?

_____

HOW OFTEN DO YOU EXERCISE? _____

FOR WOMEN ONLY

1. ARE YOU PREGNANT? IF YES PLEASE INDICATE HERE ☐
2. HAVE YOU EVER BEEN PREGNANT? IF YES,
   HOW MANY BIRTHS? _____ HOW MANY MISCARRIAGES? _____
3. PLEASE INDICATE THE RESULTS OF YOUR LAST GYNECOLOGICAL EXAM & PAP SMEAR:

GYN: _____PAP:_____

DATE OF GYN EXAM.: _____ DATE OF PAP SMEAR: _____

**** CONTINUE TO NEXT PAGE PLEASE ****

PAGE 3

In the last SIX (6) months, Which of the following Symptoms have you Experienced?

	NEVER	SOMETIMES	OFTEN
DIFFICULT TO STOP BLEEDING?	_____	_____	_____
Excessive Appetite	_____	_____	_____
Loose stools or diarrhea	_____	_____	_____
Digestion Problems	_____	_____	_____
Vomiting	_____	_____	_____
Belching or Burping	_____	_____	_____
Heartburn	_____	_____	_____
Feeling of food retention	_____	_____	_____
Cough	_____	_____	_____
Shortness of breath	_____	_____	_____
Decreased sense of smell	_____	_____	_____
Nasal problems	_____	_____	_____
Skin problems	_____	_____	_____
Feeling of claustrophobia	_____	_____	_____
Bronchitis	_____	_____	_____
Colitis or diverticulitis	_____	_____	_____
Constipation	_____	_____	_____
Hemorrhoids	_____	_____	_____
Recent use of antibiotics	_____	_____	_____
Low back pain	_____	_____	_____
Sciatica	_____	_____	_____
Knee problems	_____	_____	_____
Hearing impairment	_____	_____	_____
Ringing in ears	_____	_____	_____
Kidney stones	_____	_____	_____
Decreased sex drive	_____	_____	_____
Hair loss	_____	_____	_____
Urinary problems	_____	_____	_____
Insomnia, difficulty sleeping	_____	_____	_____
Heart Palpitations	_____	_____	_____
Nightmares	_____	_____	_____
Mentally restless	_____	_____	_____
Laughing for no apparent reason	_____	_____	_____
Angina pains	_____	_____	_____
Eye problems	_____	_____	_____
Jaundice (yellowish eyes or skin)	_____	_____	_____
Hepatitis	_____	_____	_____
Difficulty digesting oily foods	_____	_____	_____
Gall stones	_____	_____	_____
Light colored stools	_____	_____	_____

**** CONTINUE TO NEXT PAGE PLEASE ****

PAGE 4

In the last SIX (6) months, Which of the following Symptoms have you Experienced?

	NEVER	SOMETIMES	OFTEN
Soft or brittle nails	_____	_____	_____
Easily angered or agitated	_____	_____	_____
Spasms or twitching of muscles	_____	_____	_____
Fatigue	_____	_____	_____
Edema	_____	_____	_____
Blood in stools	_____	_____	_____
Easily bruised	_____	_____	_____
Asthma	_____	_____	_____
Tendency to catch colds easily	_____	_____	_____
Intolerance to weather changes	_____	_____	_____
Allergies	_____	_____	_____
Hayfever	_____	_____	_____
Tendency to faint easily	_____	_____	_____
High blood pressure	_____	_____	_____
High cholesterol	_____	_____	_____
Sudden weight loss	_____	_____	_____

Any related comments that you would like to share would be appreciated:

_____

_____

_____

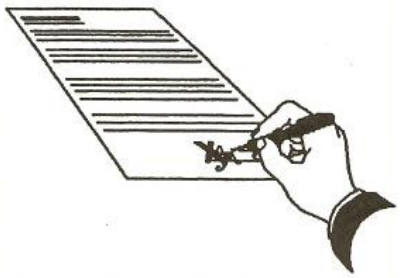
_____

_____

PATIENT'S SIGNATURE

_____

DATE: _____



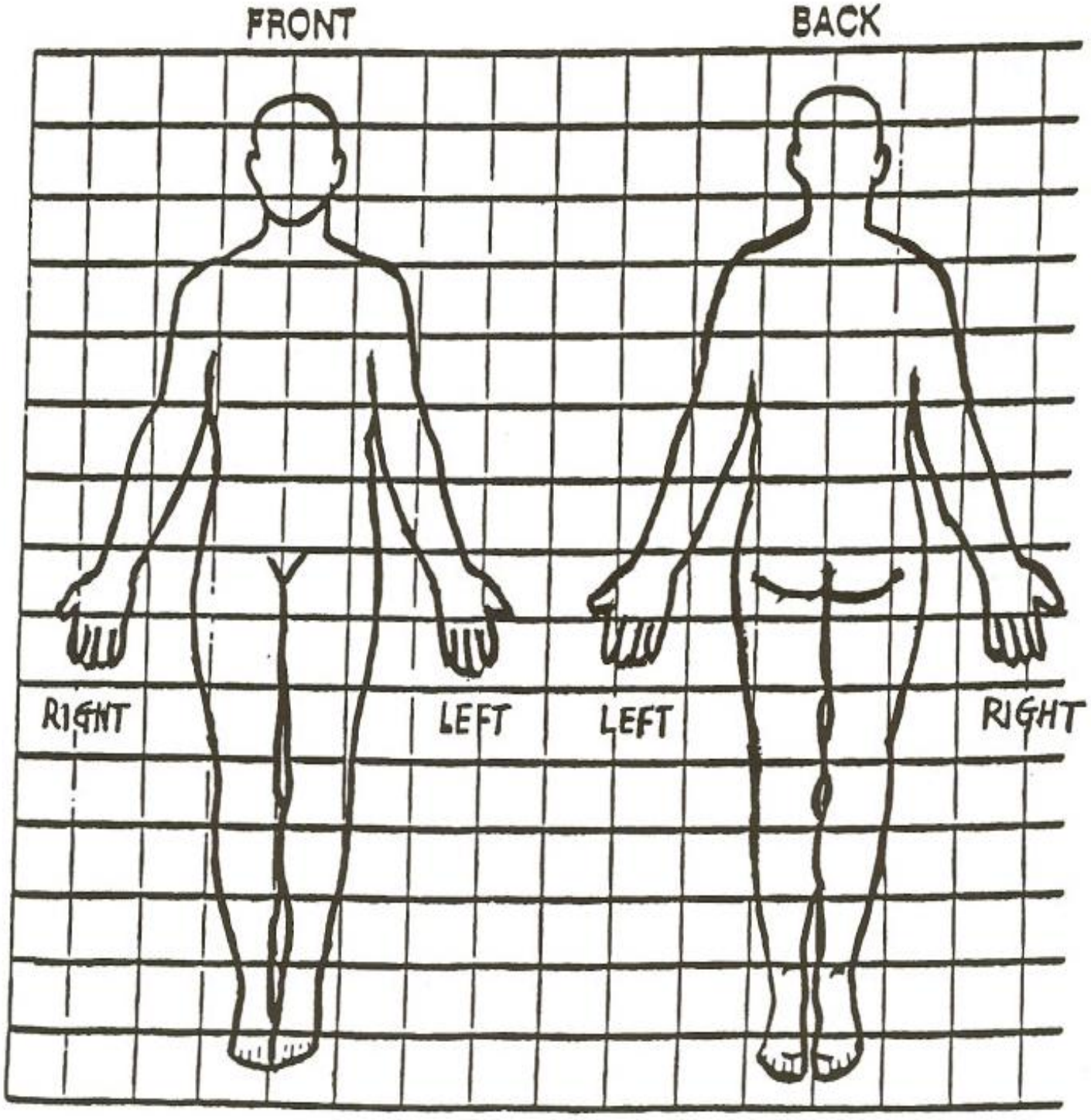
PLEASE SIGN & DATE THIS PAGE

******* IF YOU DO NOT HAVE PAIN STOP HERE *******

PAIN ASSESSMENT DRAWING GRID

DATE _____ **PATIENT'S NAME:** _____

A = ACHE **B = BURNING** **N = NUMB** **S = STABBING** **0 = OTHER**



** CONTINUE TO NEXT PAGE PLEASE **

PAGE 6

1. HOW LONG HAVE YOU HAD THE PRESENT PAIN? : _____
2. HOW LONG HAVE YOU BEEN OFF WORK OR HOUSEWORK? : _____
3. MY PAIN (CHECK APPROPRITE BOX)

BEGINS: ☐ GRADUALLY ☐ SUDDENLY
☐ FROM INJURY

IS: ☐ OFF & ON ☐ CONTINUOUS

Is worse when I:
☐ COUGH OR SNEEZE
☐ SIT DOWN
☐ BEND FORWARD
☐ LAY DOWN
☐ WAKE UP
☐ WALK

☐ AFTER SURGERY

4. HAVE ANY TREATMENTS MADE YOUR PAIN BETTER? YES ☐ NO ☐

IF yes, WHAT TYPE: _____

5. HAVE ANY TREATMENTS MADE YOUR PAIN WORSE? YES ☐ NO ☐

IF yes, WHAT TYPE: _____

GOOD JOB!!! YOU COMPLETED IT!!!