The Healing Point Intake Questionairre

Richard Blitstein L.Ac., MSTOM, Dipl. Ac., Dipl. CH

Date: _______________
Name: _____________________________ DOB ___/ ___/____ Sex: M F SS#_____________________
Address: _____________________________________ City ____________________ State: ____ Zip: ___________
Cell Phone: _____________________ Home Phone: ______________ Business Phone: ______________
Emergency Contact Name: ______________________ Contact Phone:__________________________
Occupation: ____________________ Height: _________ Weight: _________lbs.
Name of your Physician: ____
Who referred you to this office? ____

1. What brought you here today?
____
____

2. When did you first notice any problems related to what brought you here today and what symptoms did you notice?____
____
____

3. What happened since you first noticed any symptoms and up to today?
____
____
____

4. What previous medical workups, diagnosis and treatment have you had for this problem? How have these been helpful or unhelpful?
____
____
____

5. Please list any allergies to drugs or medications:
____

6. What medications or supplements are you currently taking?

Medication	Dose	How long have you been taking it?

7. Other illnesses, surgeries, injuries

Illnesses

Year	Illness	Treatment/ medications	Outcome

Surgeries

Year	Surgery	Outcome
______	______________________________	______________________________
______	______________________________	______________________________
______	______________________________	______________________________

Injuries / Trauma

Year	Injury / Trauma	Treatment	Outcome
______	______________	______________________________	______________
______	______________	______________________________	______________
______	______________	______________________________	______________

8. Family history

☐ Allergies ☐ Diabetes ☐ Emotional Difficulties ☐ Glaucoma ☐ Heart Problems ☐ Stroke
☐ Cancer ☐ Seizure Disorders ☐ Thyroid Problems ☐ Tuberculosis ☐ Hypertension/ High BP

Please check any conditions or symptoms that **you presently have** or **have had in the past:**

	Presently Have	Had in Past		Presently Have	Had in Past
Cough	☐	☐	Pneumonia	☐	☐
Cough with blood	☐	☐	Sputum/phlegm	☐	☐
Shortness of breath	☐	☐	Asthma	☐	☐
Bronchitis	☐	☐	Lack of perspiration	☐	☐
Seasonal allergies	☐	☐	Excessive perspiration	☐	☐
Chronic colds	☐	☐			
Nasal or sinus congestion	☐	☐	Nose bleeds	☐	☐
Sinus infections	☐	☐	Nasal polyps	☐	☐
Loss of smell	☐	☐			
Irregular heartbeat	☐	☐	Chest pains	☐	☐
Poor circulation	☐	☐	Heart attack	☐	☐
Dizziness	☐	☐	Low blood pressure	☐	☐
Palpitations	☐	☐	* High blood pressure	☐	☐
Fainting spells	☐	☐	* treatment ______________________		
Indigestion	☐	☐	Abdominal cramping	☐	☐
Nausea	☐	☐	Diarrhea	☐	☐
Vomiting	☐	☐	Constipation	☐	☐
Vomiting with blood	☐	☐	* Laxative use	☐	☐
Gas	☐	☐	* Product ______________________		
Bloating	☐	☐	Alternating diarrhea and constipation	☐	☐
Belching	☐	☐	Rectal pain	☐	☐

	Presently Have	Had in Past		Presently Have	Had in Past
Acid regurgitation	☐	☐	Hemorrhoids	☐	☐
Poor appetite	☐	☐	Blood in stool	☐	☐
Excessive appetite	☐	☐	Bowel movements every _______ days		
			_______ number of bowel movements / day		
Frequent urination	☐	☐	Burning on urination	☐	☐
Excessive urination	☐	☐	Difficulty urinating	☐	☐
Nighttime urination	☐	☐	Painful urination	☐	☐
Unable to hold urine	☐	☐	Blood in urine	☐	☐
Kidney stones	☐	☐	Sexually transmitted diseases	☐	☐
Bladder infections	☐	☐			
Muscle pain	☐	☐	* Joint pain	☐	☐
Muscle weakness	☐	☐	* Where ________________________________		
Muscle spasms	☐	☐	Neck pain	☐	☐
Back pain (lower)	☐	☐	Knee pain	☐	☐
Back pain (middle)	☐	☐	* Numbness	☐	☐
Back pain (upper)	☐	☐	* Where ________________________________		
Pain goes down the legs	☐	☐			
Wear glasses	☐	☐	Eye tiredness / strain	☐	☐
Blurred vision	☐	☐	Seeing spots	☐	☐
Double vision	☐	☐	Sensitivity to light	☐	☐
Cataracts	☐	☐	Eye dryness	☐	☐
Glaucoma	☐	☐	Eye redness	☐	☐
Eyes feel swollen	☐	☐	Eye itchiness	☐	☐
Pressure in the eye	☐	☐	Eye tearing	☐	☐
Eye pain	☐	☐			
Hearing difficulties	☐	☐	Loss of balance	☐	☐
Ringing in the ears	☐	☐	Ear infections	☐	☐
Ear pain	☐	☐			
Sore throats	☐	☐	Sore gums	☐	☐
Mouth dryness	☐	☐	Bleeding gums	☐	☐
Bad taste in the mouth	☐	☐	Sore tongue	☐	☐
Bad breath	☐	☐	Numbness in the tongue	☐	☐
Mouth sores / ulcerations	☐	☐	Grinding teeth	☐	☐
Changes in the skin color	☐	☐	Dandruff	☐	☐
Skin bruising	☐	☐	Eczema	☐	☐

	Presently Have	Had in Past		Presently Have	Had in Past
Skin rashes	☐	☐	Psoriasis	☐	☐
Skin acne	☐	☐	Skin ulcerations	☐	☐
Body hair changes	☐	☐			
Sudden weight loss	☐	☐	Sudden weight gain	☐	☐
Diabetes	☐	☐	Thyroid disorder	☐	☐
Anxiety	☐	☐	Problems with alcohol or drug use	☐	☐
Depression	☐	☐	Psychological crisis	☐	☐
Irritability	☐	☐	Psychoactive medications	☐	☐
Hot tempered	☐	☐	if yes which ones ___________________________		
Stress	☐	☐	Emotional difficulties	☐	☐
Fevers	☐	☐	Seizures	☐	☐
Chills	☐	☐	Concussion	☐	☐
Cold intolerance	☐	☐	Headache	☐	☐
General chilliness	☐	☐	Shaking / tremors	☐	☐
Cold hands / feet	☐	☐	Cysts / tumors	☐	☐
Heat intolerance	☐	☐	Edema / water detention	☐	☐
General warmth	☐	☐	Night sweating	☐	☐
Fatigue	☐	☐	Insomnia	☐	☐
Anemia	☐	☐	Nightmares	☐	☐
Poor memory	☐	☐			

Smoking: How much per day? ______________________________

Alcohol: How much per day? ______________________________

Nutrition

What do you typically eat for the following:
Breakfast: ______________________________
Lunch: ______________________________
Dinner: ______________________________

Exercise

What is your daily activity level related to your occupation:

☐ Sedentary i.e mostly sitting ☐ somewhat active
☐ moderately active ☐ very active (moving around or up most of the time)
☐ heavy duty (lifting, moving thingd etc.)

What kind of physical activity level (exercise, sports) do you participate in. How often per week? How long each time?

____
____

Miscellaneous:
How much water do you drink per day? ______________________________
How many caffeine containing products (coffee, tea, carbonated pop) do you drink per day? ______________
____
Snacks: ______________________________

Male Patients: Please fill out the following section

Please check any conditions or symptoms that you presently have or had in the past

	Presently Have	Had in Past		Presently Have	Had in Past
Prostate enlargement	☐	☐	Premature ejaculation	☐	☐
Prostatitis	☐	☐	Impotence	☐	☐

Female Patients: Please fill the following section

Pregnancy: Are you presently pregnant? Y N Not sure
Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), abortions (A), whether vaginal (V) or Cesarean section (C). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)

Year

_______ ____
____
_______ ____
____
_______ ____
____

Menstruation
Age of onset _____ Last Menstrual Period (first day of) ____________ Date of last Pap exam ___/___/__
Result ______________________ Length between periods ____
Regularity:
☐ regular ☐ irregular ☐ usually early by ____days ☐ usually late by ____ days ☐ varies between being early or late
How many days of menstrual flow do you usually have? ________

Flow is: ☐ even ☐ uneven ☐ heavy ☐ light
Color is: ☐ pale ☐ pink ☐ light red ☐ red ☐ deep red ☐ purplish ☐ brown
Consistency is: ☐ thin ☐ thick ☐ clotted

Discomfort with period:
☐ lower abdominal distention ☐ before ☐ during ☐ after menstruation
☐ lower back soreness ☐ before ☐ during ☐ after menstruation
☐ cramping ☐ before ☐ during ☐ after menstruation
☐ Other____

Premenstrual Syndrome (PMS)
☐ irritability ☐ bloating ☐ mood swings ☐ breast tenderness
☐ other ____

Vaginal Discharge
☐ No ☐Yes If yes, color and amount:____

Menopause:
Age of onset __________ Any difficulties / symptoms? ____

Uterine bleeding (not related to periods) Color _______________________ amount ______________________
☐ comes on suddenly ☐ all the time

Patient Informed Consent

1. I hereby voluntarily consent to be treated by acupuncture and or Chinese Herbs administered by Richard Blitstein, hereinafter referred to as "Practitioner".

2. I understand that acupuncture is performed by the insertion of fine, pre-sterilized disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.

3. I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

4. I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese herbs.

5. I understand that I may stop treatment at any time.

6. I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the energetic channels of the same name.

7. I acknowledge the fact that Richard Blitstein is not and does not profess to be a western-trained medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does the Practitioner give any substances by injection.

8. I acknowledge that Practitioner has completed a minimum of three years training In Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the state of Illinois.

9. The clinical data gathered in practice, without names, may be used for statistical research and teaching purposes.

Signature______________________________________ Date_______________________