PRINCETON ACUHEALTH
Acupuncture and Integrative Medicine

Dr. Zohra Awan, DAOM, L.Ac

Patient Information

Please fill out the following questionnaire to help us determine the best course of treatment for you. The information you provide is completely confidential. If you have any questions, please ask us. Thank you.

Last Name _____ First Name_____ Today's Date_____

Date of Birth (MM/DD/YR) _____ Height _____ Weight _____ Gender: Male ☐ Female ☐

Address _____ City _____ State _____ Zip _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email Address: _____

I would like to receive confirmation for my appointments by: Email ☐ Phone ☐

Occupation _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Emergency Contact _____ Phone (____) _____

Person Responsible for Your Account: _____

Whom should we thank for referring you to our office? _____

Have you ever had acupuncture before? _____ If yes, by whom? _____

Primary Health Care Provider/MD _____ Phone (____) _____

INSURANCE/SUPERBILL INFORMATION

Name of Insurance _____ ID# _____ Group# _____

Address _____ Phone _____

Name of Insured _____ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Assignment of Benefits for Insurance: I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize payment of benefits to be made directly to this healthcare provider. I also authorize the release of any information, including diagnosis and records of treatment, requested to process this claim.

_____

Patient Name (print) Patient Signature Date

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Medical History

Please indicate any illnesses you or a relative (grandparent, parent, aunt/uncle, sibling) have had:

Condition	Self	Relative	Date Diagnosed	Condition	Self	Relative	Date Diagnosed
Heart Disease	☐	☐	_____	Asthma	☐	☐	_____
High Blood Pressure	☐	☐	_____	Glaucoma	☐	☐	_____
Diabetes	☐	☐	_____	Depression	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Disease	☐	☐	_____	Dementia/Alzheimer's	☐	☐	_____
Thyroid Disease	☐	☐	_____	Bleeding Disorders	☐	☐	_____
Stroke	☐	☐	_____	Seizures	☐	☐	_____
Cancer	☐	☐	_____	Tuberculosis	☐	☐	_____

Sexually Transmitted Diseases _____

Are you currently under the care of any of the following medical professionals?

☐ Medical Doctor ☐ Chiropractor ☐ Acupuncturist ☐ Physical Therapist
☐ Naturopath ☐ Massage Therapist ☐ Nutritionist ☐ Psychiatrist

Have you ever had any of the following illnesses?

☐ Rheumatoid Fever ☐ Chicken Pox ☐ Scarlet Fever ☐ Measles
☐ Mumps ☐ German Measles ☐ Polio ☐ Diphtheria

Check if any of the following is true:

☐ I have a pacemaker ☐ I am taking Coumadin/Warfarin
☐ I have surgical implants ☐ I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Surgical History

Please list any surgeries, hospitalizations, or accidents you have had:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Medications / Supplements

List any medications and supplements you are currently taking (continue on back if needed):

Medicine	Illness	Dosage	How Long	Prescribed by	Date Last Checkup

Allergies (to medications, chemicals, food, insects, environmental):

_____ _____
_____ _____
_____ _____
_____ _____

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Health Questionnaire

What are the main problems for which you are seeking treatment?

_____

_____

Have you received a diagnosis for your condition by a physician? Please describe.

_____

_____

What other forms of treatment have you sought?

_____

_____

List any other health problems you have now.

_____

_____

Lab Results (Please provide us with a copy).

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Age of last period (menopause) _____ Are you taking birth control? ☐ Yes ☐ No What kind/how long? _____

Indicate number of occurrences: Live Births _____ Pregnancies _____ Miscarriages _____ Abortions _____

Date of Last: Gynecologic Exam _____ Pap Smear _____ Mammogram _____ Bone Density Scan _____

Results: _____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other _____

Is your menstrual cycle regular? ☐ Yes ☐ No Cycle length: _____ Days of flow: _____

Average # of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ 5th day _____ + days _____

The flow is: ☐ Normal ☐ Heavy ☐ Light The color is: ☐ Pale Red ☐ Bright Red ☐ Dark Red ☐ Purple ☐ Brown

The consistency is: ☐ Thick ☐ Dilute (watery)

Clots? ☐ Yes ☐ No Color: _____

Location of Pain: ☐ Lower Abdomen ☐ Low Back ☐ Thighs

Nature of Pain: (indicate before, during, or after period)

Cramping _____ Stabbing _____

Dull_____ Aching _____

Bloating _____ Burning _____

Continuous _____ Intermittent _____

Bearing down sensation _____

Symptoms related to menses:

☐ Swollen Breasts ☐ Constipation ☐ Diarrhea

☐ Nausea/Vomit ☐ Poor Appetite ☐ High Appetite

☐ Headache ☐ Migraine ☐ Mood Swings

☐ Vaginal Dryness ☐ Discharge ☐ Yeast Infections

☐ Hot Flashes ☐ Night Sweats ☐ Insomnia

☐ Increased Libido ☐ Low Libido ☐ Anxiety

☐ Bleeding between periods ☐ Discharge between periods

For Men

Date of Last Prostate Exam _____ PSA Results _____

Frequency of Urination: Daytime _____ Nighttime _____ Color of Urine: ☐ Clear ☐ Murky Odor: _____

Check all that apply:

☐ Prostatitis ☐ Delayed Urine Stream ☐ Incontinence ☐ Urine Retention ☐ Dribbling

☐ Impotence ☐ Premature ejaculation ☐ Increased Libido ☐ Decreased Libido ☐ Other

☐ Groin Pain ☐ Testicular Pain ☐ Back Pain ☐ Rectal Dysfunction

Have you sought medical intervention for these problems? ☐ Yes ☐ No If yes, what/when? _____

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Symptom Survey (for everyone)

The following is a list of symptoms you may or may not experience. Please indicate as follows:

No Mark = never experience ✓ = sometimes experience X = frequently experience

__ Lack of appetite
__ Excessive appetite
__ Loose stools or diarrhea
__ Digestive problems
__ Vomiting
__ Belching/burping
__ Obsessiveness in work/relationships
__ Heartburn/acid reflux
__ Insomnia/difficulty sleeping
__ Heart palpitations
__ Cold hands/feet
__ Excessive sleeping
__ Nightmares
__ Mental restlessness
__ Fatigue

__ Abdominal pain
__ Chest pain
__ Sciatic pain
__ Headaches
__ Pain/coldness in genitals
__ Cough
__ Shortness of breath
__ Decreased sense of smell
__ Nasal problems
__ Skin problems
__ Bronchitis
__ Eye problems
__ Constipation
__ Hemorrhoids
__ Colitis or diverticulitis

__ Jaundice (yellow eyes/skin)
__ Difficulty digesting oily foods
__ Gallstones
__ Light colored stools
__ Soft, brittle nails
__ Easily angered/agitated
__ Difficulty making decisions
__ Spasms/twitching of muscles
__ Low back pain
__ Knee problems
__ Hearing impairment
__ Ear ringing
__ Kidney stones
__ Decreased sex drive
__ Hair loss

__ Edema
__ Blood in Stool
__ Black Tarry Stool
__ Easily Bruised
__ Difficulty to stop bleeding
__ Asthma
__ Tendency to catch colds
__ Allergies
__ Hay Fever
__ Dizziness
__ Tendency to faint easily
__ Sudden weight loss
__ Blurry Vision
__ Floaters
__ Recent use of antibiotics

Lifestyle, Diet, & Nutrition

Exercise	☐ Sedentary (no exercise) ☐ Mild Exercise (recreation or activity at work) ☐ Regular Exercise (3x/wk for 30 min) ☐ Vigorous Exercise (5 days/wk for 60 min) Comments: _____
Sleep	☐ Difficulty falling asleep ☐ Difficulty waking up in the morning ☐ Difficulty staying asleep Hours of sleep/night: _____
Diet	Do you follow a special diet: ☐ Yes ☐ No Please describe (i.e. vegetarian, vegan, low-carb, etc): _____ Number of meals you eat on an average day: _____ Drink Preference: ☐ Hot ☐ Room Temperature ☐ Cold Food Preference: ☐ Salty ☐ Spicy ☐ Sweet ☐ Sour ☐ Bitter Food Cravings: _____ Food Intolerance/Restrictions: _____

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	☐	☐	_____	Alcohol	☐	☐	_____	Water Intake	☐	☐	_____
Non-medical Drugs	☐	☐	_____	Tobacco	☐	☐	_____	Soda	☐	☐	_____

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing:

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Sleep	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

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Patient Profile

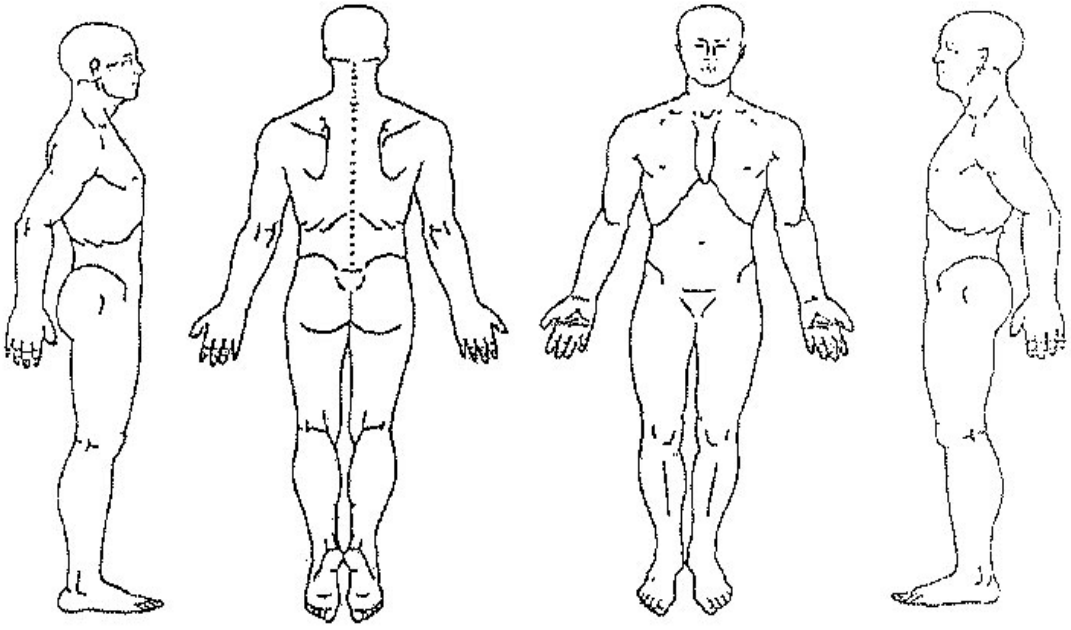
Please clearly mark any areas of pain (with XXX's), scars (with - - - -), and numbness (with OOO's).

Is the pain: ☐ Sharp ☐ Burning ☐ Aching ☐ Cramping ☐ Dull ☐ Radiating ☐ Fixed ☐ Other:_____

Do the following lessen the pain? ☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other:_____

Do the following worsen the pain? ☐ Pressure ☐ Cold ☐ Heat ☐ Exercise ☐ Other:_____

Is the pain worse in the morning or in the evening? _____



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