

Welcome to the world of natural healthcare and thank you for giving me the opportunity to be your practitioner. I look forward to our time together, and I am excited to share with you this profound healing art.

Your first appointment will last approximately two hours, during which time you will have the opportunity to speak at length about your health concerns, questions and goals. I will talk with you about your medical and social history and perform a physical exam. This exam is to evaluate the balance of energy in your body and provides me with the information necessary to treat you safely and appropriately. The exam is different from a physical done by a doctor. You may or may not receive a needle treatment during your first visit. Your subsequent visits will be for approximately one hour.

To assist my diagnosis, please do not wear fragrances or makeup on the day of your appointment.

Please complete the Health History Form and Fax it to me at 301-617-9724 or bring it to your first appointment.

On my website is information regarding: fees, payment, directions and insurance. If you need to change an appointment, please contact me at 301-725-8927 a minimum of 24 hours prior to the scheduled appointment time.

Please help me provide you with a complete evaluation by taking the time (about 15 minutes) to fill out this questionnaire carefully. All answers are confidential.

Name: _____ Email: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of birth: _____ Age: _____ Height: _____ Weight: _____

Telephone: Home () _____ Work () _____ Cell () _____

Do you wish to receive the Seasonal E-newsletter? Yes / No

Single _____ Married _____ Divorced _____ Widowed _____ Living with _____

Education: _____ Occupation: _____

Children Names & Ages:

Referred by: _____

Reason for visit today: _____

Other concerns: _____

How long have you had this condition? _____ Have you ever experienced this before? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your: Sleep _____ Work _____ Other (what?) _____

FAMILY HISTORY - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

	Self	Mother	Father	Sibling	Spouse	Children
Cancer or tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Seizures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Age of death						
Hepatitis						
Kidney disorders						
Thyroid disorders						
Muscular-skeletal disorder						
Blood transfusion (if before 1985)						
Parkinson's disease						
Pituitary disorders						
AIDS						

Please put a "C" if the condition is current or a "P" if you had it in the past

General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Lethergy / Inertia
- Poor memory
- Difficulty making decisions
- Anxious or worried
- Hopeless or negative
- Cry easily
- Fearful / Fearless
- Loose temper easily
- Difficult to accept sympathy
- Difficult to express joy
- Easily startled
- Extremely organized
- Spiritual
- Ever considered suicide
- Recent weight loss/gain
- Cold hands or feet
- Tends to push when exhausted
- Inflexible
- Lyme Disease
- Broken bones
- Nails split/crack
- Swelling of hands/feet
- Tumors / growths
- Night sweating
- Excess sweating
- Difficulty being still / relaxing
- Water retention / bloating
- Easily overheats or overchills
- Needs to sleep a lot

Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands
- Hair loss / thinning

Ears

- Ringing
- Hearing loss /Hearing aids
- Infections / Earache
- Vertigo
- Motion, air or seasickness

Eyes

- Glasses/ contact lenses
- Blurred vision / double vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Glaucoma / Cataracts
- Pain or itching

- Watery or too dry
- Recent laser surgery

Nose, Throat & Mouth

- Sinus infection
- Hay fever / allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed / Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth
- Loss of taste or smell

Skin

- Hives / Rashes
- Eczema/ Psoriasis
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching
- Dandruff
- Recent Dermabrasion
- Recent Botox

Respiratory

- Difficulty breathing
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High / low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles / Phlebitis
- Anemia
- History of heart attack
- Varicose Veins

Gastrointestinal

- Nausea / vomiting
- Indigestion / slow digestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite

- Excessive/ deficient hunger
- Flatulence
- Burping / Hiccups
- Acid regurgitation
- Bloating
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Liver / Gall Bladder disorder
- Colitis / Diverticulosis
- Crohns
- Ulcer

Musculoskeletal Joint pain/disorder

- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Back pain
- Rib pain
- Limited range of motion

Other (describe) _____

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Epilepsy or convulsions
- Fainting spells

Other (describe) _____

Genital-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

Infection Screening

- Parasites
- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- STD's: self or partner
- Genital warts
- Herpes: oral/ genital

Other: _____