Melissa Murtha, LAc, MA

Acupuncturist at Braun Chiropractic, PC

This is a CONFIDENTIAL questionnaire to help me determine the best treatment plan for you. If you have questions, please ask. Thank you.

Personal Information

Name______________________________ Date____________

Home Address______________________________

City____________________ State__________ Zip__________

Home Phone__________ Email____________________ Work Phone__________

Occupation______________ Person responsible for your account______________

Emergency Contact: Name____________________ Phone__________

Who should we thank for referring you to this office?______________________________

Sex: ❑ Male ❑ Female ❑ Trans ___MTF___FTM Height______ Weight______ Birthdate__________ Age______

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑Widowed ❑ Partnered Number of children______

Have you received acupuncture therapy before? ❑ Yes ❑ No

When?____________________ With whom?____________________

Please indicate any significant illness you or a blood relative (grandparent, parent, or sibling) have had:

Illness	*You*	*Your Relative*	*Approx. Date*	*Illness*	*You*	*Your Relative*	*Approx. Date*
Cancer	❑	❑	______	Diabetes	❑	❑	______
Hepatitis	❑	❑	______	Heart Disease	❑	❑	______
High Blood Pressure	❑	❑	______	Seizures	❑	❑	______
Rheumatic Fever	❑	❑	______	Emotional Disorders	❑	❑	______
Infectious Diseases	❑	❑	______	Tuberculosis	❑	❑	______

Sexually Transmitted Diseases: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ Chlamydia ❑ Herpes Date ______

List any medications and supplements you are currently taking: (Continue on back if necessary.)

Medicine	*Dosage*	*Reason*	*How long*	*Prescribed by*	*Date of last checkup*

Check the box if any of the following statements are true:

❑ I have known allergies
❑ I have a pacemaker
❑ I am taking Coumadin/Warfarin
❑ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

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

What other forms of treatment have you sought?______________________________

List any other health problems you now have.______________________________

List any accidents, surgeries, or hospitalizations (include date).______________________________

List any allergies, food sensitivities, or food cravings you have.______________________________

Please indicate the use and frequency of the following:

	Yes	No	How much		Yes	No	How much		Yes	No	How much
Coffee/black tea	❑	❑	______	Tobacco	❑	❑	______	Water	❑	❑	______
Non-medical drugs	❑	❑	______	Alcohol	❑	❑	______	Soda pop	❑	❑	______

OB/GYN History

Age of 1st period (menarche) ____________ Are you pregnant? ❑ Yes ❑ No # of pregnancies________

Age of last period (menopause) ___________ # of live births______ # of abortions______ # of miscarriages________

Number of days between periods __________ Date of last: Gynecologic Exam ___________ Pap Smear __________

Number of days of flow _______________ Mammogram _____________ Bone Density Scan _____________

Color of flow ____________________ Results ____

Clots? ❑ Yes ❑ No Color ____________ ____

Average number of pads you use per day: 1st day_____ 2nd day_____ 3rd day______ 4th day______ + days__________

Have you been diagnosed with: ❑Fibroids ❑Fibrocystic Breasts ❑Endometriosis ❑Ovarian Cysts ❑PID Other______

Location of Pain: ❑ Lower Abdomen ❑ Lower Back ❑ Thighs ❑ Other ______________________________

Nature of Pain (Please indicate before, during, or after menses)

Cramping ___________ Stabbing _____________

Burning ____________ Aching ______________

Dull ________________ Bloating _____________

Consistent __________ Intermittent ___________

Bearing down sensation _____________________

Other symptoms related to menses:

❑ Discharge ❑ Vaginal dryness ❑ Headache

❑ Nausea ❑ Constipation ❑ Diarrhea

❑ Swollen breasts ❑ Mood swings ❑ Ravenous appetite

❑ Poor appetite ❑ Hot flashes ❑ Night sweats

❑ Increased libido ❑ Decreased libido ❑ Insomnia

Urogenital History (Men only)

Date of last prostate check up ___________ PSA results ___________ Manual prostate exam results ___________

Lab results ____

Frequency of Urination: daytime _________ nighttime _________ Color of urine: ❑ clear ❑ murky odor: _________

Symptoms related to prostate

❑ Prostate problems ❑ Delayed stream ❑ Post-void dribbling ❑ Incontinence ❑ Retention of urine

❑ Erectile dysfunction (ED) ❑ Increased libido ❑ Decreased libido ❑ Premature ejaculation ❑ Impotence

❑ Back pain ❑ Groin pain ❑ Testicular pain ❑Decreased force of stream ❑ BPH/Enlarged prostate

❑ Other ____

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no mark ___ = never experience, check mark ✓ = sometimes experience, plus sign + = frequently experience

___lack of appetite
___excessive appetite
___loose stool or diarrhea
___digestive problems, indigestion
___vomiting
___belching, burping
___heartburn/reflux
___feeling retention of food in the stomach
___tendency to become obsessive in work, relationships...

___insomnia, difficulty sleeping
___heart palpitations
___cold hands and feet
___nightmares
___mentally restless

___angina pains
___abdominal pain
___chest pain
___sciatic pain
___headaches
___pain or cold in the genital area

___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

___eye problems
___jaundice (yellowish eyes or skin)
___difficulty digesting oily foods
___gallstones
___light colored stool
___soft or brittle nails
___easily angered or agitated
___difficulty in making plans or decisions
___spasms or twitching of muscles

___low back pain
___knee problems
___hearing impairment
___ear ringing
___kidney stones
___decreased sex drive
___hair loss

___urinary problems
___fatigue
___edema
___blood in stool
___black tarry stool
___easily bruised
___difficult to stop bleeding
___asthma
___tendency to catch colds easily
___intolerance to weather changes
___allergies
___hay fever
___dizziness
___tendency to faint easily
___high cholesterol levels
___sudden weight loss