ELIZABETH C. CHRISTENSON, MD, LAc.

DATE:_____

INSTRUCTIONS: THIS PROFILE CONTAINS QUESTIONS THAT WILL HELP US TO BETTER UNDERSTAND YOUR UNIQUE SITUATION. PLEASE READ AND ANSWER EACH AND EVERY QUESTION CAREFULLY, AND PRINT YOUR ANSWERS CLEARLY. IF YOU FEEL THAT SOMETHING NEEDS TO BE CLARIFIED OR ADDED, PLEASE FEEL FREE TO PROVIDE ADDITIONAL INFORMATION. BECAUSE THIS INVENTORY IS YOUR ACCOUNT OF YOUR PERSONAL EXPERIENCE, PLEASE COMPLETE IT BY YOURSELF AND AS DETAILED AS POSSIBLE.

DEMOGRAPHIC INFORMATION

(1) NAME: _____ (2) AGE: _____

PATIENT'S MOTHER'S MAIDEN NAME: _____

(3) ADDRESS: _____
(Street) (City) (State) (Zip)

(4) HOME PHONE: ( )_____ (5) WORK PHONE: ( )_____

(6) HEIGHT: _____ (7) WEIGHT: _____ (8) BIRTHDATE:_____

(9) SEX: ( ) Male ( ) Female: PRIMARY LANGUE: English: Other: Translator:

(10) MARITAL STATUS: ( ) Married ( ) Remarried ( ) Single ( ) Divorced ( ) Separated ( ) Widowed

(11) ETHNIC GROUP: ( ) Caucasian ( ) Black ( ) Hispanic ( ) Asian ( ) Other _____

(12) WITH WHOM DO YOU LIVE? _____
NEXT OF KIN: NAME_____ RELATIONSIP: _____
PHONE: _____ADDRESS: _____

(13) HOW MANY CHILDREN DO YOU HAVE? _____

(14) PRESENT OR MOST RECENT OCCUPATION: _____

(15) SPOUSE'S OCCUPATION: _____

(16) PRESENT RELIGIOUS AFFILIATION (Optional): _____

(17) RELIGIOUS BACKGROUND (Optional): _____

(18) WHO REFERRED YOU TO THIS CLINIC?

Refer Doctor's Name: _____ Phone: ( ) _____

Other Source: _____ Phone: ( ) _____

(19) WHAT IS YOUR CURRENT EMPLOYMENT STATUS?

( ) 1. Employed full time
( ) 2. Employed part time
( ) 3. Retired
( ) 4. Homemaker
( ) 5. Unemployed due to pain
( ) 6. Unemployed for other reasons (Describe) _____

(20) HAS YOUR PAIN FORCED YOU TO GIVE UP OR CHANGE YOUR TYPE OF WORK?
___Yes ___No

(21) IF UNEMPLOYED, HOW LONG HAVE YOU BEEN OUT OF WORK?
____ Months ____Yrs.

(22) IS THERE ANY LEGAL ACTION PENDING AS A RESULT OF THIS PROBLEM?
____Yes ____No

(23) WHAT ARE YOUR PRESENT SOURCES OF FINANCIAL SUPPORT? (Check all that apply)

( ) 1. Personal funds ( ) 2. Workman's Compensation ( ) 3. Disability
( ) 4. Insurance (Name) _____
( ) 5. Other sources (Describe). _____

(24) WHAT WAS THE HIGHEST GRADE YOU COMPLETED?

( ) 1. Less than high school
( ) 2. High School
( ) 3. Technical or business school
( ) 4. College
( ) 5. Graduate or professional school
( ) 6. Other (Describe) _____

PRESENT ILLNESS

(25) LIST ANY COMPLAINTS IN ORDER OF SEVERITY, PERIOD AND TYPE OF TREATMENT:
_____

_____

_____

_____

_____

_____

(26) ARE YOU OTHERWISE IN GOOD HEALTH? YES NO

(27) WHEN WAS YOUR LAST ROUTINE PHYSICAL? _____

(28) ARE YOU BEING TREATED FOR ANYTHING OTHER THAN YOUR PAIN? YES NO
*IF YOU HAVE BEEN TREATED FOR PAIN, OR ARE SEEKING PAIN TREATMENT, PLEASE ASK FOR PAIN FORMS. IF YES, EXPLAIN:
_____

_____

_____

_____

(29) ARE YOU TAKING ANY MEDICATIONS OTHER THAN FOR YOUR PAIN? YES NO

(30) PLEASE LIST THOSE MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN IN THE LAST 6 MONTHS OTHER THAN FOR YOUR PAIN: (Use a separate sheet if necessary).

MEDICATION NAME & DOSAGE (mg) # TAKEN DAILY/ when started?

1. _____
2. _____
3. _____
4. _____
5. _____

HERBAL & VITAMIN SUPPLEMENT

(NAME & DOSAGE) # TAKEN DAILY/ when started?

1. _____
2. _____
3. _____
4. _____
5. _____

PAST MEDICAL HISTORY:

(31) PLEASE LIST ANY OPERATIONS AND HOSPITALIZATIONS YOU HAVE HAD AND THE DATES THEY OCCURRED:

A) _____

B) _____

C) _____

D) _____

E) _____

(32) PLEASE LIST ANY TRAUMA OR ACCIDENTS YOU HAVE HAD AND THE DATES THEY OCCURRED:

A) _____

B) _____

C) _____

D) _____

E) _____

(33) PLEASE LIST ANY OCCUPATIONAL STRESSES (CHEMICAL, PHYSICAL, PSYCHOLOGICAL).OR PSYCHIATRIC CARE YOU HAVE HAD IN THE PAST OR NOW /OR HISTORY OF ABUSE:

A) _____

B) _____

C) _____

(34) HAVE YOU EVER HAD A BLOOD TRANSFUSION? IF YES, WHEN_____ NO

(35) HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	IF YES, WHEN & TREATED BY WHOM	NO
01 Rheumatic fever			
02 Scarlet fever			
03 Diabetes			
04 Epilepsy			
05 Hemophilia			
06 Bleeding tendencies			
07 Blood diseases			
08 Anemia			
09 Asthma			
10 Tuberculosis			
11 Lung disease			
12 Heart disease			
13 Liver disease			
14 Kidney disease			
15 Thyroid disease			
16 Measles			
17 Mumps			
18 Chicken pox			
19 Hepatitis			
20 Venereal disease			
21 Ulcers			
22 Stroke			
23 Cancer, Type:			
24 Emotional problems			
25 Other.			

(36) ARE YOU SENSITIVE OR ALLERGIC TO ANY FOODS OR ENVIRONMENTAL FACTORS?
YES NO IF YES, WHAT? _____

_____

_____

WHEN WAS THE DIAGNOSIS OR WHEN WAS THE SKIN TEST? _____

FOLLOW UP CARE BY WHOM _____SINCE WHEN_____

(37) ARE YOU SENSITIVE OR ALLERGIC TO ANY OF THE FOLLOWING:

	YES	CONDITION OF REACTION	NO
01 Penicillin			
02 Aspirin			
03 Codeine			
04 Iodine			
05 "Novacaine"			
06 "Sleeping pills"			
07 Other (please list)			

(38) EXERCISE;

TYPE _____

HOW MANY YEARS? _____

HOW OFTEN? _____

HAVE YOU HAD ANY LOSS OF ENERGY OR A REDUCTION IN EXERCISE TOLERANCE? _____

(39) DIET:

MORNING _____

NOON _____

EVENING _____

SNACK _____

SPECIAL DIET _____

Appetite: __ Normal, __ Poor, __ Strong, __ Hunger with (or no) desire to Eat
Change in appetite (when started & how)_____
Thirst: __ Normal, __ Poor, __ Strong, __ Thirst with (or no) desire to Drink
Prefer foods: __ Hot, __Cold, __ Raw, __ Cooked.
Prefer drinks: __ Hot, __Cold.
Cravings _____ Aversion_____
Feel after meals: __ Tired, __ Bloated, __ Energized,
__ Weight loss, __ Weight gain, How much_____when_____
Did you do anything to correct your weight change? _____

_____

_____

_____

(40) FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY HAD THESE PROBLEMS? DIABETES. CANCER (TYPE)

_____

HYPERTENSION, HEART DISEASE, STROKE, SEIZURES, ASTHMA, ALLERGIES, ALCOHOLISM. ETC.
PLEASE INDICATE WHO. HOW LONG & MEDICATION
(EXAMPLE: DIABETES, TAKING INSULIN OR ORAL HYPOGLYCEMIC)

_____

_____

Family history of Hepatitis: who has A, B, C, or other _____
How many siblings do you have? ___ Are they older or younger than you? _____
How many years older or younger than you? _____
Any sibling rivalry or any abuse issues(s) might have caused emotional trauma in your young age ? (use separate page). _____

_____

(41) HABITS;

Did you grow up in a smoking environment? _____ Who smoke? _____
Are you currently expose to smoker(s) in your environment? _____

A) CIGARETTES: WHEN STARTED_____HOW MANY PACK/DAY _____
CIGAR / PIPE : WHEN STARTED _____ HOW MANY/DAY_____
B) CESSATION (i) WHEN: _____
(ii) TYPE OF TREATMENT: _____
(iii) RESTART WHEN:_____
C) COFFEE: HOW MANY/DAY _____
D) COLA: HOW MANY/DAY_____
E) ALCOHOL: TYPE_____HOW OFTEN _____
F) ILLICIT DRUGS: WHEN STARTED_____ WHAT KIND _____
CESSATION (i) WHEN: _____(ii) TYPE OF TREATMENT _____
(iii) RESTART: _____

(42) REVIEW OF SYSTEM:

GENERAL (Circle all pertinent)

Body Temperature: *__ Normal, __ Fever, __ Chills, __ Sense of Heat - where in body_____, When occur_____,*
___ Sense of Cold: ____ Cold hands, ____Cold feet, ___ Cold back, __ Cold abdomen
Aversion to: __ Wind, __ Cold, __ Heat, Other _____

Perspiration: *__ Normal,* __ Sweat easily, *___ Only with Exercise, ____ Night sweat, ___ Spontaneous sweat - anytime without exercise, when_____ __ Profuse sweat: where?___ Whole body or Specific area* _____
Odor of sweat: ___ weak, ___ strong.

Sleep*: Time to Bed _____, Time to Wake _____, Hours sleep per night* _____
Quality of sleep: ___ Good, ___ Poor, ___ Heavy, ___ Light.
___ Difficulty Falling Asleep, ___ Difficulty Staying Asleep, ___ Difficulty Waking, ___ Dream disturbed, ___ Nightmares, Note: _____

Energy: *Scale of 1 – 10 ____, Best time _____, Worst Time _____.*
Sudden energy drop (what time) _____ Localized weakness (where) _____
Fatigue, since when _____associate with _____

_____

SKIN AND HAIR
__ Dry, __ Oily, __Rashes, __Ulcerations, __Hives, __Itching, __Eczema, __Pimples, __ Dandruff, __ Loss of hair, __ Change in hair/skin texture, __ Dry / cracked nails, __Purpura, Bleed or bruise easily (where) _____
Other hair or skin problem _____

HEAD, EYES, EARS, NOSE AND THROAT

Headaches: __ Nape of neck (*Tai Yang*), __ Forehead (*Yang Ming*), __Vertex (*Jue Yin*),
__ Temples and sides of head (*Shao Yang*), __ Whole head (*exterior invasion of Wind-Cold*).
__ Migraines, __ Concussions, __ Dizziness / Vertigo,

Eyes: __ Poor vision, __ Glasses, __ Eye strain, __ Eye pain, __ Night blindness, __ Cataracts, __ Color blindness, __ Blurry vision, __ Earaches, __ *Red,* __ *Itchy,* __ *Watery,* __ *Gritty,*
__ *Dry,* __ *Floaters* (Spots in eyes).

Ears: __ Ringing in ears: __ High Pitch, __ Low Pitch, __ Poor hearing, __ Discharge, __ Ear pain.
Nose: __ Nose bleeds, __ Mucus: __ Clear, __ White, __ Yellow, __Green, __ Thick, __ Thin.
Sinus problems: Explain _____
Throat: Recurrent sore throats _____/ month, __ Sore throat, __ Dry throat,
__ Swollen glands, __ Difficulty swallowing.

Mouth: __ Dry mouth, __ Excess & Copius saliva, __ Teeth problems, __ Jaw clicks,
__ Grinding teeth, __ Gum problems, __ Bleeding, __ Swollen.
__ Facial pain, __ Sores on lips or tongue, __ Ulceration (Mouth, tongue, lip).
Peculiar & abnormal tastes/smells _____
NECK: ___neck pain, ___swellings, __ stiffness**.**

CARDIOVASCULAR
__ High blood pressure, __ Low blood pressure, __ palpitations, __ Chest pain, __ Irregular heartbeat,
__ Dizziness, __ Fainting, __ Cold hands/feet, __ Swelling in hands/feet, __ Blood clots,
__Phlebitis, __ Difficulty breathing, __ *Palpitations,* __ *Short of breath,*
__ Other _____

RESPIRATORY
__ Cough, __ Coughing blood, __ Asthma, __Wheeze, __ Bronchitis, __ Pneumonia,
__Dyspnea (difficult breathing), __ Orthopnea (difficulty in breathing when lying down),
__ *Chest Tightness,* __ *Chest heaviness.*
Production of phlegm_____ what color _____
__ Other _____

GASTROINTESTINAL
__ *Halitosis (Bad breath),* __ *Nausea,* __ *Vomiting,* __ *Diarrhea,* __ *Indigestion,* __ *Flatulence,*
__ *Belching,* __ *Acid Reflux.*

Bowel Movement: Frequency _____times / day or ____ / week, Usual Time of day _____
Color: __ Light brown, __Dark brown, __ Black.
Odor: __ Strong, __ Weak, __ None.
Consistency: __ Normal, __ Hard, __ Loose, __ Constipation, __ w / difficulty, __Diarrhea,
__ Alternating, __ undigested Food, __ Blood, __ Mucous. Feels complete: __ Yes, __ No.

Laxative use: _____ /week; type _____
When started _____. Last use _____

Abdomen: __ Sensitive, __ pain or cramps, __ Swelling / where _____
__ Rectal pain, __ Hemorrhoids**.**

GENITO-URINARY
Frequency: _____ times / Day. Amount: __ Copious, __ Scanty, __ Moderate.
Odor: __ Strong, __ Weak, __ None.
Color: __ Clear, __ Light Yellow, __ Dark Yellow, __ Brown, __ Red.(Blood in urine).
Other: __ Cloudy, __ Urgent, __ Painful urination, __ Burning, __ Retention,
__ Unable to hold urine (incontinence), __ dribbling, __ Kidney stones.
__ Wake up to urinate: How often _____/night; what time _____.
__ Venereal disease, __ Impotency
__ Other G/U problems: _____

FOR MEN
Sexual energy: __ Normal, __ High, __ Low.
Sexual Disorders: __ Impotence, __ Premature ejaculation, __ Erectile Dysfunction,
__ *Prostatitis,* __ Enlarged prostate.
__ Abnormal discharge from penis, __ Blisters on penis, __ Ulcer on penis,
__ Pain in testicles, __ Difficulty in starting urine, __ Urine dribbles out, __ Hernia,
__ Vasectomy done, When? _____
Other:_____
MUSCULOSKELETAL
Location of disorder (s): _____
Pain: __ Neck, __ Shoulder, __ Back pain (where) _____
__ Joint pain (where) _____
Other joint or bone problems? _____

Pain is: __ Sharp, __ Dull, __ Burning, __ Cramping, __ Fixed in one place - where_____
__ Moving, __ Radiating to _____
Pain Better with: __ Heat, __ Cold, __ Pressure, __ Movement.
Pain worse with: __ Heat, __ Cold, __ Pressure, __ Movement.

Others: __ Weakness, __ Numbness, Where _____
__ Spasms, where _____
Tremors (where) _____, ___At rest, or ____During movement.

Poor coordination, since when _____

__ Swelling / Edema, where _____

NEUROPSYCHOLOGICAL
__ Seizures, __ Areas of numbness, where _____
__ Disorientation, __ clumsiness,
__ paresthesias (abnormal spontaneous sensation, such as buringing, pricking, numbnes, etc.)
__ Easily stressed, __ Poor memory, __ Considered attempted suicide.
__ Other neurological or psychological problems? _____
Describe each checked above symptom:
How often _____
When was last manifestation _____
Medication _____
How long have you been on it _____
When was last taken _____

TCM Primary emotion: __ Joy, __ Worry, __ Sadness, __ Fear, __ Anger, __ Indecision,
__ Depression, __ Anxiety, significant past emotional states _____
_____
__ Concussion, __ *Loss of Consciousness, Describe:* _____

FOR WOMEN:
Age when periods first started: _____, Are periods regular? __ Yes, ___ No.
How often are your periods? _____
How many days does the period last?_____,
Date of last menstrual period (LMP):_____Was it normal? __ Yes, __ No.
Color: __ Bright Red, __ Dark Red, __ Reddish-Purple, __ Brown.
Flow: __ Normal, __ Heavy, __ Light, __ Spotting blood between periods,
Painful periods: __ Pain in lower abdomen, __ Heaviness in lower abdomen, __ *Back pain.*
Other: __ Clots, __ Cramping, __ Breast tenderness, __ Breast lumps, __ Fatique,
__ Mood swings, __ Painful intercourse, __ Spotting blood after **sex.**
Cravings: Food _____, __ Sweet, __ Salty, __ Sour, __ Bitter, __ Spicy,
Vaginal discharges: Color: __ White, __ Yellow.
Odor: __ Strong, __ Weak.
Sexual energy: __ Normal, __ High, __ Low.
Any sexual difficulties _____

Birth control being used? Specify Type _____
When started ?_____
When stopped ?
_____

PAP SMEAR AND CHLAMYDIA SCREENING (females, every 1-3 yrs)
___Yes ___No ___PT refused

Number of pregnancies ____, Live births _____, Miscarriages ____, Abortions _____, Stillbirths _____
Premature births (less than 8 months) _____, Number of children alive now _____
Have had a baby weigh more than 9 lbs. at birth. __ Yes, __ No.
Menopause? _____ When started? _____
Are you on Hormonal replacement therapy? ___ Yes, __ No. If yes, type _____
When started? _____ When stopped?_____

TYPE OF DELIVERY	DATE: MONTH & YEAR	GESTATION	COMPLICATIONS

HAWAII ADVANCE DIRECTIVE PLANNING FOR IMPORTANT HEALTH-CARE DECISIONS:
Discussed With PT/Written Information Provided. ___Yes ___ No ___ PT Refused ___PT will fill form

PREVENTIVE SERVICES / RISK SCREENING (leave blank if you do not know):

VISION screen: (age 65 +) ___ Both Eyes ___Right eye ____ Left eye ___
HEARING screen: (age 65 +) ____ Normal response to speech ____Refer to hearing test
PNEUMOCOCCAL VACCINE (age 65 +)___ Yes ___ No ___PT refused
TETANUS / DIPHTHERIA VACCINE___ Yes ___No ___PT refused
DYSLIPIDEMIA SCREEN (every 5 years or more, if indicated)___Yes ___No ___PT refused
MAMMOGRAM SCREENING (age 50-74)___Yes ___No ___PT refused
COLORECTAL CANCER SCREEN (age 50+) ___Yes ___No ___PT refused

IMMUNIZATION RECORD: MMR)___Yes ___No DPT)___Yes ___No
HEPATITIS A___Yes ___No , HEPATITIS B___Yes ___No,
OTHER:

1.) List 3 aspects of yourself you feel good about.

1. _____

2. _____

3. _____

2.) List 3 aspects of yourself that you would like to change.

1. _____

2. _____

3. _____

3.) List 3 major goals for today.

1. _____

2. _____

3. _____

4.) List 3 major goals for this year.

1. _____

2. _____

3. _____

5.) List 3 major goals for your life.

1. _____

2. _____

3. _____

6.) Why do you want to live?

7.) What are your goals in coming to this office?

8.) What made you choose Complementary & Alternative Medicine / Integrative Medicine a treatment?

9.) What would you do if you don't get benefit from this type of treatment?

10.) Have you ever had acupuncture treatment before? If yes, when?

11.) What were you treated for?

12.) Were you satisfied with the result? Please make comment on your experience.

13.) Had you ever had any fainting spell or seizure when had needle stick in your body, such as getting blood drown or other medical procedures including acupuncture? If yes, describe the incidence.

14.) Additional comments: