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This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name _____ Age _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Wireless Phone _____

Email _____

Birthdate _____

If under 18, person responsible for your account _____

Emergency Contact: Name _____

Emergency Contact Phone: _____

Occupation _____

Hobbies _____

Living situation _____

How did you hear about me? _____

Have you had acupuncture therapy before? How was it?

What would you like to achieve with acupuncture treatment?

Please CIRCLE if any of the following pertain to you (marking “yes” does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

Hepatitis B/C HIV/AIDS High Blood Pressure Seizures Blood-Thinning Medication
Pacemaker Current Pregnancy

Please indicate the use and frequency of the following:

Coffee _____ Soda _____ Tea _____ Water _____

Alcohol _____

Recreational drugs _____

Tobacco (include history) _____

Exercise _____

Name and phone number of primary care physician: _____

Please list any prescription or over-the-counter medications you are presently taking:

| Medication & Dosage (incl. Supplements) | Reason / How long |
|---|-------------------|
|---|-------------------|

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Health History

Please list your health concerns in order of priority:

1. _____
2. _____
3. _____

Please give answers about your primary complaint: When did it start?

What was happening in your life then?

What other forms of treatment have you sought?

What helps your condition?

What aggravates your condition?

How severe is it? Does it interfere with your daily life?

Is it worse or better at a particular time of day? _____

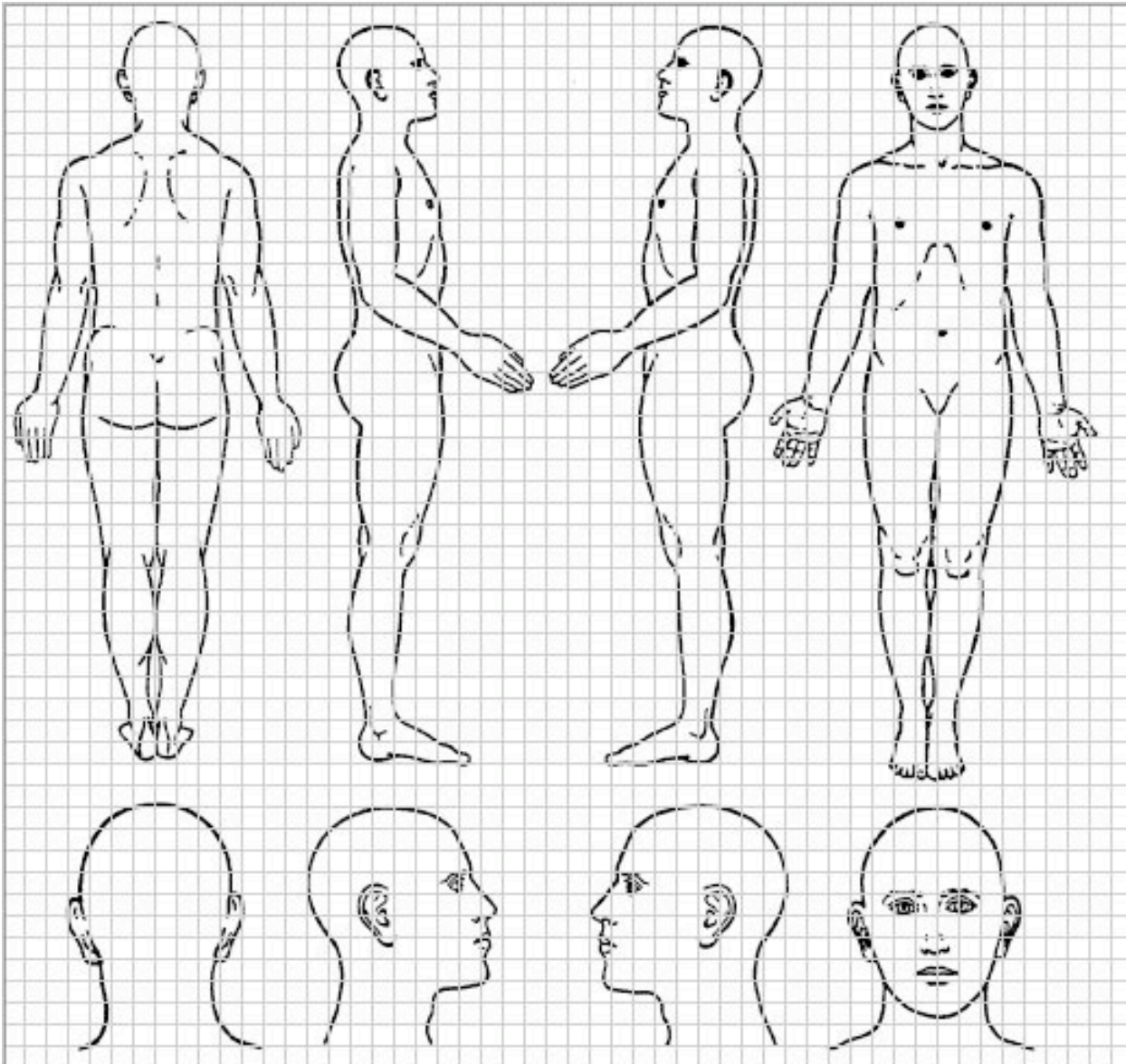
Please list any surgeries or major health incidents (accidents, etc.) in your life

Childhood illnesses

Adult illnesses

What do you believe is causing your most important health concerns?

PAIN PATIENTS, Please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain?

___dull/achy ___sharp/stabbing ___burning ___tingling ___numbness ___electrical

On a scale of 0-10, 0 being no pain, and 10 being the worst pain imaginable, how do you feel?

Family History (if deceased, note cause and age at death)

Siblings / Children

| | Mother | Father | Partner | | |
|------------------------------|---------------|---------------|----------------|--|--|
| Age | | | | | |
| diabetes | | | | | |
| tuberculosis | | | | | |
| heart disease | | | | | |
| high/low BP | | | | | |
| stroke | | | | | |
| kidney disease | | | | | |
| cancer | | | | | |
| arthritis | | | | | |
| anemia | | | | | |
| headaches | | | | | |
| mental illness | | | | | |
| neurological problems | | | | | |
| other issues | | | | | |

Review of Systems:

General:

Height _____ Weight _____ Recent weight changes _____

Energy level 1-10 ____ Do you tend to feel hot or cold compared to everyone else? ____

For Women

Age of first period _____ Date of last period _____

Are you currently experiencing any gynecological symptoms or problems? _____

Are you currently sexually active? _____ Partner(s) is/are __Male __Female

If sexually active, do you perform safe sex practices? _____

Any problems with sexual desire or function? _____

History of sexually transmitted diseases? _____

Number of pregnancies? _____ Births? _____ Abortions? _____ Miscarriages? _____

Any complications or female surgeries _____

Date of last Pap Smear? _____ Abnormal Pap? _____

How frequent do you have a gyn exam/ pap smears? _____

Any cervical cancer history? _____ if yes, when: _____

Any ovarian cancer history? _____ if yes, when: _____

Do you perform regular breast self exams? ____yes ____no

If menopausal or perimenopausal: List symptoms and concerns: _____

When regular periods stopped? _____

Any personal history of breast cancer? _____

Number of days between periods (your cycle) _____

Number of days of flow _____

For Women

Color of flow:

pale/light red
 red
 bright red
 dark red
 brown
 clots

Amount

spotting
 light
 even throughout
 moderate
 heavy

Pain and cramping:

None
 before flow
 after flow
 during flow
 mild
 severe

Other GYN symptoms:

Discharge PMS Swollen Breasts Mood Swings

Have you ever been diagnosed with:

fibroids fibrocystic breasts
 endometriosis ovarian cysts PID polycystic ovary syndrome

For Men

Are you currently sexually active? Partner(s) is/are Male Female

If sexually active, do you perform safe sex practices? _____

History of sexually transmitted diseases? _____

Date of last prostate exam? _____

Trouble with sexual function/libido? If yes, explain: _____

For Everyone

CIRCLE any current complaint and UNDERLINE any past complaints, then provide details on the line below.

Sleep:

Amount per night? _____ Fall asleep easily? _____ Wake easily during the night? _____

If so, is it to urinate? _____ If wake, fall back asleep easily? _____

Wake easily? _____ Feel rested in morning? _____ Sleep propped up? _____

Vivid dreams Nightmares Naps needed Night sweats /chills Painful to lie down Apnea

Psychological:

Depression Anger Anxiety Stress Irritability Other emotional upset _____

Neurological:

Headache Migraine Head injury Loss of Consciousness Stroke Fainting:Dizziness
Blackout Seizures Paralysis Local weakness Numbness Tingling Tremors
Difficulty thinking/ confusion Difficulty with memory _____

Skin:

Rashes Lumps Itching Dryness Slow healing Easy / unexplained bruising Hair loss
Color change Hair loss Nail problems _____

Eyes:

Last eye exam _____
Glasses/ Contact lenses Pain Redness Tearing Double Vision Glaucoma Cateract

Ears:

Hearing problems Tinnitus Vertigo Balance Earaches Infection Discharge

Nose & Sinus:

Sinus congestion Nose running Hay fever/ allergies Nosebleeds Loss of smell

Mouth & Throat:

Last dental exam _____
Bleeding gums Sore tongue Frequent sore throat Speech disorder Chronic halitosis

Neck:

Lumps Swollen glands Goiter Neck pain

Breasts:

Lumps Tenderness Nipple Discharge

Respiratory:

Last chest X-ray_____Sputum (color, quantity): _____

Cough Difficulty breathing Shortness of breath Wheezing Asthma Bronchitis
Emphysema Pneumonia Tuberculosis Pleurisy

Cardiac:

Chest pain Palpitations Lightheaded / dizziness Heart Attack High /low blood pressure
Heart murmur Edema

Gastrointestinal:

Low appetite Excess hunger Nausea Vomiting Difficulty swallowing Indigestion
Heartburn / Reflux Gastric pain Abdominal pain Constipation Diarrhea Food allergies
IBS Excess belching / gas Hemorrhoids Bowel incontinence Rectal bleeding
Gall bladder disease Gall stones Jaundice Liver disease Hepatitis
Freq of bowel movements: _____Color _____
Formed / loose / soft / hard
Recent change in BM _____

Urinary:

Frequency_____Color _____

Cloudy Bloody Frequent urination At night Painful Burning Urgency Hesitancy
Trouble stopping Incontinence Urinary tract infection Kidney stones

Musculoskeletal:

Pain Stiffness Swelling Redness Weakness Limited range of motion Arthritis Gout
Neck Shoulders Arms Hands Upper back Middle back Lower back Ribs Hips
Legs Knees Ankles Feet

Peripheral vascular:

Intermittant claudication (pain with exercise) Cramps Hot/cold extremities Varicose veins

Endocrine:

Thyroid disease Heat/cold intolerance Excess sweating Diabetes / hypoglycemia
Excess thirst

Hematologic:

Anemia Easy bruising / bleeding Transfusion history

Immunity:

Frequent colds/flu HIV /AIDS Autoimmune disease Exposure to toxins

Anything else?

INFORMED CONSENT

I understand that although all efforts will be made to ensure that my treatment is as painless and side-effect-free as possible, sometimes life is not perfect.

I understand that although the acupuncture needles are sterile, and my skin will be cleaned, there is a small risk of infection.

I understand that there is a risk of bleeding, bruising, or pain with needling.

I understand there are a few serious risks associated with acupuncture, such as pneumothorax (punctured lung) or nerve irritation.

I understand that with moxibustion there is a small risk of burns.

I understand that cupping may create round red marks that may lead people to think I have been attacked by an amorous squid.

I understand that therapeutic bodywork may result in soreness or bruising.

I understand that there are no guarantees with regard to treatment outcome, and that symptoms may become worse after treatment.

I understand that I am free to withdraw this consent and stop treatments at any time.

With this knowledge, I voluntarily consent to acupuncture, moxibustion, cupping, and therapeutic bodywork, and agree to release Sharon Rose from any liability that may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care.

CANCELLATION POLICY

I understand that if I cannot keep an appointment I need to call as soon as possible. I understand that cancellation within 24 hours of the appointment creates a hardship for both the Rose Family Clinic and for patients who may have wanted that time slot, and that I may be charged for that appointment.

Date _____

Patient name (printed) _____

Patient signature _____

Parent / Legal Guardian's name (if applicable) _____

Parent / Legal Guardian's signature _____