Jade Mountain Health
Andrew C. Maloney, L. Ac.
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303.859.3125
www.jademtnhealth.com

HEALTH HISTORY QUESTIONNAIRE

Please help us to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers are held *absolutely* confidential. If you have questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the "Comments" section. Thank you.

Today's Date: _____

Name: _____ **Email:** _____

Address: _____ **City:** _____ **Zip:** _____

Home: (_____) _____ **Work:** (_____) _____ **ext.** _____ **Cell/other:** (_____) _____

Age: _____ **Date of Birth:** _____ **Place of Birth:** _____ **Marital Status:** _____

Family Physician: _____

Emergency Contact: _____

Referred by: _____

Have you been treated with acupuncture or Oriental medicine before? ❑ Yes ❑ No

Main problem(s) you would like us to help you with: _____
_____

When did this condition begin? (Be as specific as possible.) _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____
_____

Have you been given a diagnosis for this problem? If so, what? _____

What kind of treatment have you tried, and with what result? _____
_____
_____

Your significant illnesses (please indicate dates in space provided, if possible):

❑ Cancer (_____) ❑ Diabetes (_____) ❑ Hepatitis (_____)
❑ Heart disease (_____) ❑ Seizures (_____) ❑ High blood pressure (_____)
❑ Venereal disease (_____)
❑ Other (please describe): _____

Surgical procedures: _____
_____
_____

Significant traumas (auto accident, fall, etc.): _____
_____
_____

Unusual conditions present during your birth (prolonged labor, forceps delivery, etc.): _____
_____

Allergies (drugs, chemicals, foods, etc.): _____
_____

Has anyone in your family suffered from:

❑ Diabetes ❑ Cancer ❑ High blood pressure
❑ Heart disease ❑ Stroke ❑ Seizures
❑ Asthma ❑ Allergies
❑ Other (please describe): _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____
_____

Occupation: _____

Occupational stress (physical, psychological, chemical, etc.): _____

Do you have a regular exercise program? ❑ Yes ❑ No Please describe: _____
_____

Have you been on a restricted diet? ❑ Yes ❑ No Please describe: _____

Please describe your average daily diet:

Morning: _____
Afternoon: _____
Evening: _____
Other: _____

Do you smoke? ❑ Yes ❑ No If so, how often and how much? _____

How many caffeinated beverages do you drink per day or week? _____

Please check if, *in the last three months*, you have experienced the following:

GENERAL

- ❑ Poor appetite
- ❑ Poor sleeping
- ❑ Fatigue
- ❑ Fevers
- ❑ Chills
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Tremors
- ❑ Cravings
- ❑ Localized weakness
- ❑ Poor balance
- ❑ Change in appetite
- ❑ Bleed or bruise easily
- ❑ Weight loss
- ❑ Weight gain
- ❑ Peculiar tastes or smells
- ❑ Strong thirst (cold or hot drinks)
- ❑ Sudden energy drop (During what time of day?_____)

SKIN AND HAIR

- ❑ Rashes
- ❑ Ulcerations
- ❑ Hives
- ❑ Itching
- ❑ Eczema
- ❑ Pimples
- ❑ Dandruff
- ❑ Loss of hair
- ❑ Recent moles
- ❑ Change in hair/skin texture
- ❑ Other (please describe): _____

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Dizziness
- ❑ Concussions
- ❑ Migraines
- ❑ Glasses/contact lenses
- ❑ Eye strain
- ❑ Eye pain
- ❑ Poor vision
- ❑ Night blindness
- ❑ Color blindness
- ❑ Cataracts
- ❑ Blurry vision
- ❑ Earaches
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Spots in front of eyes
- ❑ Sinus problem
- ❑ Nose bleeds
- ❑ Recurrent sore throats
- ❑ Grinding teeth
- ❑ Facial pain
- ❑ Sores on lips or tongue
- ❑ Teeth problem
- ❑ Jaw clicks
- ❑ Headaches (What part of the head, and when?) _____
- ❑ Other (please describe): _____

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Dizziness
- ❑ Fainting
- ❑ Cold hands or feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Phlebitis
- ❑ Difficulty in breathing
- ❑ Other (please describe): _____

RESPIRATORY

- ❑ Cough
- ❑ Coughing up blood
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Pain with a deep breathing
- ❑ Other (please describe): _____

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Belching
- ❑ Black stools
- ❑ Blood in stools
- ❑ Indigestion
- ❑ Bad breath
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Abdominal pain or cramps
- ❑ Chronic laxative use
- ❑ Other (please describe): _____

GENITO-URINARY

❑ Painful urination ❑ Frequent urination ❑ Blood in urine
❑ Urgency to urinate ❑ Unable to hold urine ❑ Kidney stones
❑ Decrease in flow ❑ Impotence ❑ Sores on genitals
❑ Other (please describe): _____

Do you wake up at night to urinate? ❑ Yes ❑ No How often? _____
Any particular color to your urine? ❑ Yes ❑ No Please describe: _____

GYNECOLOGY AND PREGNANCY

❑ Irregular periods ❑ Painful periods ❑ Clots
❑ Vaginal discharge ❑ Vaginal sores ❑ Breast lumps
❑ Unusual character of period (heavy or light) ❑ Change in body/emotions prior to period
❑ Other (please describe): _____

First date of last menstrual period: _____ **Duration:** _____
Number of days between menstrual periods: _____ **Date of most recent Pap:** _____

Number of pregnancies: _____ **Number of births:** _____ **Number of premature births:** _____
Number of miscarriages: _____ **Number of abortions:** _____

Do you practice birth control? ❑ Yes ❑ No
What method, and for how long? _____

MUSCULOSKELETAL

❑ Neck pain ❑ Muscle pains ❑ Knee pain
❑ Back pain ❑ Muscle weakness ❑ Foot/ankle pains
❑ Hand/wrist pains ❑ Shoulder pain ❑ Hip pain
❑ Other (please describe): _____

NEUROPSYCHOLOGICAL

❑ Seizures ❑ Dizziness ❑ Loss of balance
❑ Areas of numbness ❑ Lack of coordination ❑ Poor memory
❑ Concussion ❑ Depression ❑ Anxiety
❑ Bad temper ❑ Easily susceptible to stress
❑ Other (please describe): _____

Have you been treated for emotional problem? ❑ Yes ❑ No

Have you ever considered or attempted suicide? ❑ Yes ❑ No

COMMENTS

Please describe any other problems you would like to discuss: _____
_____
_____

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DISCLOSURE STATEMENT

Welcome to Jade Mountain Health. Please read and sign this disclosure. If you have any questions, please feel free to ask for clarification before you sign it.

Initial Visit: $195
Follow up : $125

Andrew C. Maloney received a four-year M.S. in Oriental Medicine from the Southwest Acupuncture College, Boulder Campus. He is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and is a licensed acupuncturist (Lic. # ACU925) in the State of Colorado; he has never had a license, certificate, or registration suspended or revoked.

Mr. Maloney is trained and experienced in the recommendation and application of adjunctive therapies such as gua sha, cupping, moxibustion, tui na, and the use of herbal poultices. He is also a trained Chinese herbalist with experience both in the U.S. and abroad. All of these adjunctive therapies fall under the definition of traditional oriental medicine. He worked and studied acupuncture in Taiwan for five years (1994-1999); in the last year before returning to the U.S., he apprenticed under Dr. Yo Mao Ling in Luo Dong, Taiwan.

This disclosure statement complies with the State of Colorado, Department of Regulatory Agencies; and C.R.S. §§ 12-29.5-101, *et seq*. This clinic strictly adheres to all rules and regulations set forth by the Department of Health, including sanitation of the office and Clean Needle Technique procedures for the sterilization, a practice in which Mr. Maloney is certified.

You are entitled to receive information about methods of therapy, the technique used, and the duration of therapy (if known). You may seek a second opinion from another health care professional or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the Department of Regulatory Agencies, 1560 Broadway #1550, Denver, CO 80202 (303.894.7758). Any services offered by Mr. Maloney are not intended to substitute for those offered by a licensed medical doctor when needed. Referrals are made for further treatment when appropriate.

I have read the above statements and I understand it to my satisfaction. I certify that I have had the opportunity to have any and all questions answered about this information and I freely seek the services offered. I also understand that payment is expected at the time of service.

_____ _____

Signature Date

_____

Print Name