



# The Keller Clinic

## Acupuncture, Herbs & Nutrition

The following is a confidential questionnaire, which will help us determine the best possible treatment plan for you. Please take your time and complete the information accurately.

### PERSONAL INFORMATION

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Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact- Name \_\_\_\_\_ Phone \_\_\_\_\_

Whom should we thank for referring you to our clinic? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

When were you last seen by a medical doctor?

Date \_\_\_\_\_ Name of Physician \_\_\_\_\_

Reasons for Visit \_\_\_\_\_

Diagnosis \_\_\_\_\_

Have you ever been treated with acupuncture or Chinese herbal medicine? Yes / No  
If yes, please fill in the name and city of the practitioner.

Name of Practitioner \_\_\_\_\_ City \_\_\_\_\_

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## MEDICAL HISTORY

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What are the health problems for which you are seeking treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

What other forms of treatment have you sought? \_\_\_\_\_

\_\_\_\_\_

What helps your condition? \_\_\_\_\_

What aggravates your condition? \_\_\_\_\_

Indicate the accident, injuries and hospitalizations you have had:

1. \_\_\_\_\_ Date or Age \_\_\_\_\_

2. \_\_\_\_\_ Date or Age \_\_\_\_\_

3. \_\_\_\_\_ Date or Age \_\_\_\_\_

4. \_\_\_\_\_ Date or Age \_\_\_\_\_

Have you had \_\_\_ Measles \_\_\_ Mumps \_\_\_ Chickenpox? (Please check.)

List any childhood illnesses you may have had. (i.e. pneumonia, strep throat... etc.)

\_\_\_\_\_

Frequent use of antibiotics as a child? \_\_\_\_\_

How often do you take antibiotics now? What for? \_\_\_\_\_

Date of most recent use of antibiotic \_\_\_\_\_

What would you like to achieve with acupuncture treatment? \_\_\_\_\_

History of dental problems? Root canals? \_\_\_\_\_

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## FAMILY HISTORY

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In your family is there any history of:

	NO	YES	FAMILY MEMBER
Autoimmune disease	_____	_____	_____
Arthritis	_____	_____	_____
Asthma	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Hepatitis	_____	_____	_____
Hypertension	_____	_____	_____
Hypoglycemia	_____	_____	_____
Kidney Disease	_____	_____	_____
Mental Illness	_____	_____	_____
T.B.	_____	_____	_____
Thyroid Disease	_____	_____	_____
If yes, ___ Hashimotos or ___ Graves?	_____	_____	_____
Wheat Allergy	_____	_____	_____

## MEDICATION & PRESCRIP + OVER THE COUNTER

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Please list all prescription medication and over-the-counter products.

Name	Purpose	How Long	Dose	How Often	Last Dose

## SUPPLEMENTS + HERBS

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Please list all vitamins, supplements, herbs, and any other natural products.

Name	Purpose	How Long	Dose	How Often	Last Dose

Please answer the following question:

- Are you allergic to any of the following substances? Please List.

Medications / Drugs \_\_\_\_\_

Food /Supplements \_\_\_\_\_

Other \_\_\_\_\_

- Do you have \_\_\_ Bronchitis \_\_\_ Asthma \_\_\_ Eczema \_\_\_ Strep Throat (Check)
- Do you drink coffee or black tea? \_\_\_\_\_ If so, how much a day?  
\_\_\_\_\_
- Do you smoke cigarettes? \_\_\_\_\_ If so, how many a day? \_\_\_\_\_
- Do you drink alcohol? \_\_\_\_\_ If so, how often? \_\_\_\_\_
- Do you drink soda? \_\_\_\_\_ Diet soda? \_\_\_\_\_ If so, how often? \_\_\_\_\_
- Do you eat sugar? \_\_\_\_\_ If so, how often, what kind? \_\_\_\_\_
- Do you exercise? \_\_\_\_\_ If so, how often? \_\_\_\_\_

WHICH OF THE FOLLOWING SYMPTOMS HAVE YOU EXPERIENCED IN THE  
LAST SIX MONTHS? CHECK AND CIRCLE THE ONES THAT ARE MOST  
TROUBLESOME.

SP/ST

- |   |   |
|---|---|
| <input type="checkbox"/> Low Appetite                 | <input type="checkbox"/> Gum Problems                 |
| <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Heartburn                    |
| <input type="checkbox"/> Cold Hands & Feet            | <input type="checkbox"/> Tendency to Become Obsessive |
| <input type="checkbox"/> Bruises Easily               | <input type="checkbox"/> Hypothyroid                  |
| <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Hypoglycemic                 |
| <input type="checkbox"/> Bloating                     | <input type="checkbox"/> Hemorrhoids                  |
| <input type="checkbox"/> Loose Stools/Diarrhea        | <input type="checkbox"/> Weakness in Limbs            |
| <input type="checkbox"/> Food Allergies/Sensitivities | <input type="checkbox"/> Crave Sweets                 |
| <input type="checkbox"/> Bad Breath                   | <input type="checkbox"/> Difficulty Focusing          |

LU/LI

- |   |   |
|---|---|
| <input type="checkbox"/> Grief                          | <input type="checkbox"/> Cough with Thick Mucus     |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Cough with Thin Mucus      |
| <input type="checkbox"/> Nasal Problems                 | <input type="checkbox"/> Skin Rashes, Eczema, Hives |
| <input type="checkbox"/> Frequent Colds/Virus           | <input type="checkbox"/> Sweating Without Exercise  |
| <input type="checkbox"/> Respiratory Allergies/Hayfever | <input type="checkbox"/> Frequent Sore Throats      |
| <input type="checkbox"/> Shortness of Breath, Wheezing  | <input type="checkbox"/> Constipation               |

KI/UB

- |  |  |
|--|--|
| <input type="checkbox"/> Frequent Urination                | <input type="checkbox"/> Hearing Impairment or Ringing in Ears |
| <input type="checkbox"/> Frequent Urinary Tract Infections | <input type="checkbox"/> Weakness or Pain in Knees             |
| <input type="checkbox"/> Decreased Sex Drive               | <input type="checkbox"/> Poor Memory                           |
| <input type="checkbox"/> Hair Loss                         | <input type="checkbox"/> Fearful                               |
| <input type="checkbox"/> Premature Graying                 | <input type="checkbox"/> Insomnia                              |
| <input type="checkbox"/> Bone Loss                         | <input type="checkbox"/> Dark Circles or Puffiness Around Eyes |
| <input type="checkbox"/> Salt Craving                      | <input type="checkbox"/> Water Retention, Swelling, or Edema   |
| <input type="checkbox"/> Weakness/Pain in Lower Back       |  |

HT/SI

- |   |  |
|---|--|
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Craving Cool Drinks               |
| <input type="checkbox"/> Heart Palpitation        | <input type="checkbox"/> Easily Overheats and/or Perspires |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> Craving Spicy Food                |
| <input type="checkbox"/> Vivid Dreams             | <input type="checkbox"/> Easy Blushing of Face/Chest       |
| <input type="checkbox"/> Sores in Mouth or Tongue |  |

LV/GB

- Dry Eyes or Floaters
- Difficulty Making Plans/ Decisions
- Pain Under Ribs
- Irritability
- Light Colored or Floating Stool
- Tight Neck & Shoulders
- Spasm or Twitching of Muscles
- Clenching Teeth
- Impatience
- Bitter Taste in Mouth
- Fat Intolerance
- Depression
- High Cholesterol

WOMEN ONLY

- Hot Flashes
- On the Birth Control Pill
- Sore or Swollen Breasts Before Period
- Water Retention
- Night Sweats
- Infertility
- Scanty Menses
- No Period
- Ovarian Cysts
- Irregular Period
- Heavy or Prolonged Menstruation
- PMS
- Mood Swings
- Habitual Miscarriage
- Vaginal Discharge
- Heavy Menses
- Bleeding Between Periods
- Breast Lumps
- Uterine Fibroids
- Uterine Hemorrhage

Age when started Menses \_\_\_\_\_  
How long are your menstrual cycles? \_\_\_\_\_  
How many days of bleeding? \_\_\_\_\_  
Age when started Menopause \_\_\_\_\_  
Number of Pregnancies \_\_\_\_\_ Age \_\_\_\_\_  
Miscarriages \_\_\_\_\_ Age \_\_\_\_\_  
Number of Abortions \_\_\_\_\_ Age \_\_\_\_\_

Fertility Medications? \_\_\_\_\_

Name	Year