Beaumont Integrative Medicine - Health Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinicians during your consultations.

First Name:______________________ Middle Name:__________________ Last Name:_______________________

How would you like to be addressed? ____

Address:_________________________________ City:_____________________ State:______ ZIP:______________

Home Phone: (______)________-________ Birthdate: ______/_____/_____ Age:________

Place of Birth: ____ (City/State/Country)

Mobile Phone: (______)_______-_________ Home Phone: (______)_______-_________

Gender: ___________ Marital Status: ______________ Primary Care Physician: _____________________________

Referred by: ____

Best Number to Call: ____ May we leave a message? Yes or No

Email Address: ____

Beaumont Health – Integrative Medicine will never sell or transfer your personal information to third parties

May we send you updates & information? ☐ Yes ☐ No

Can your practitioner contact you periodically by email? ☐ Yes ☐ No

This is a CONFIDENTIAL questionnaire. Patient MRN:______________ Date of Initial Visit:___________

Emergency Contact: ____

What aspects of your health are most important to address at this time? Please list your health concerns in order of importance to you:

____

____

____

Name some positive elements in your life:

____

____

____

Are you in a supportive relationship: ______________ In a relationship you would like to change: ___________________

Do you have someone that you can confide in? ____

Do you feel unsafe in your own home? ________ Have you ever been physically, emotionally, or sexually abused? (Y/N)

If you are experiencing physical, emotional, or sexual harm from someone, please talk to me so that I can help.

Medical History Timeline: Please indicate the timing (your age) of any major events (births, deaths, marriage, divorce, abuse, job changes, health issues, traumatic events)

Your birth: Full Term: ____ Premature:____ Vaginal delivery: ____ C-Section: ____ Breast Fed:____ Bottle Fed: _____

Any issues during the pregnancy or birth?____

Childhood (birth → 17years)

Events/health issues: ____

Young Adult (18 → 29)

Events/health issues: ____

Adult (30 → 59)

Events/health issues: ____

Adult (60 → 80+)

Events/health issues: ____

For Females:

Number of pregnancies: _______ Number of live births: ________ Last menstrual period: _________________________

Any problems related to menstrual cycles. Breasts, uterus, or ovaries?

____

Allergies: Are you allergic to any medications or foods? ☐ Yes ☐ No

If yes, please list: ____

Alcohol Use: Do you regularly consume alcohol? ☐ Yes ☐ No

If yes, please indicate the quantity: # of drink(s) per ☐ day, ☐ week, ☐ month (please check one). Type: ______________

Recreational Drug Use: Have you ever used recreational drugs? ☐ Yes ☐ No

If yes, please list: ____

Tobacco Use: Have you ever used tobacco? ☐ Yes ☐ No

If yes, number of years? ___________ Amount per day? _____________ Year quit: _____________

Personal Life

What level of education have you completed? ____

Current employment: ____

Medications: What medications are you currently taking? Please include non-prescription drugs:

Medication Name	Date Started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Supplements: Please list all vitamins, minerals, and other nutritional supplements that you are currently taking (please indicate mg or IU)

Vitamin/Mineral/Supplement Name	Date Started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Nutrition: What is your typical choice of food and drink for the following:

- Breakfast: ____
- Lunch: ____
- Dinner: ____
- Snack: ____

Are you on a special diet? ____

Do you develop any symptoms after eating certain foods?

____

How much water do you drink per day? ____

How much caffeine do you consume? ____

Do you use artificial sweeteners? If so, which one(s)? ______________________________

Exercise/Movement

What types of exercise do you participate in (i.e. cardio, strengthening, yoga…)?

____

How do you feel after exercise? ____

Sleep/Relaxation

How many hours of sleep do you get per night? __________________________________

Do you awaken refreshed? ____

Stress/Grief

Any significant life changes recently? ____

Does your stress level interfere with your enjoyment of life, your sleep or your relationships?

____

Religion/Spirituality

Do you engage in regular prayer or meditation? __________________________________

Leisure/Rejuvenation

What brings you joy? ____

How do you manage your stress? ____

Integrative Medicine Review of Systems

Please indicate if you have had any of the below symptoms in the past 7 days

Constitutional/General		
Fever	YES	NO
Difficulty Managing Weight	YES	NO
Food Cravings	YES	NO
Poor Appetite	YES	NO
Binge Eating/Drinking	YES	NO
Fatigue	YES	NO
Restlessness	YES	NO
General Weakness	YES	NO
Low Stamina	YES	NO
Skin/Nails		
Rash	YES	NO
Acne	YES	NO
Vitiligo	YES	NO
Rosacea	YES	NO
Eczema	YES	NO
Psoriasis	YES	NO
Itching	YES	NO
Hives	YES	NO
Thin, Cracking or Peeling Nails	YES	NO
Nail Fungus	YES	NO
Discolored Nails	YES	NO
Nails with Ridges	YES	NO
Nails with Pits	YES	NO
HENT		
Hearing Loss	YES	NO
Ringing in Ears	YES	NO
Ear Pain	YES	NO
Sore Throat	YES	NO
Hoarse Voice	YES	NO
Clearing Throat Often	YES	NO

Canker Sores	YES	NO
Dental Cavities	YES	NO
Gums Sore/Swollen	YES	NO
Tongue Sore	YES	NO
Nasal Congestion	YES	NO
Bad Breath	YES	NO
Eyes		
Itching	YES	NO
Watering	YES	NO
Redness	YES	NO
Drainage	YES	NO
Bags Under Eyes	YES	NO
Dark Circles	YES	NO
Eyelid Irritation	YES	NO
Change in Vision	YES	NO
Light Sensitivity	YES	NO
Cardiovascular		
Chest Pain	YES	NO
Palpitations	YES	NO
Respiratory		
Cough	YES	NO
Wheezing	YES	NO
Difficulty Breathing	YES	NO
Gastrointestinal/Abdominal		
Reflux	YES	NO
Belching	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Cramping	YES	NO
Abdominal Pain	YES	NO
Burning Sensation	YES	NO
Diarrhea	YES	NO

Constipation	YES	NO
Excess Gas	YES	NO
Bloating	YES	NO
Hemorrhoids	YES	NO
Mucus in Stool	YES	NO
Blood in Stool	YES	NO
Black Stools	YES	NO
Rectal Pain	YES	NO
Stool Incontinence	YES	NO
Stool Pattern		
How often		
Color		
Consistency		
Genitourinary		
Frequency	YES	NO
Pain with Urination	YES	NO
Up at Night to Urinate	YES	NO
Incontinence	YES	NO
Blood in Urine	YES	NO
Genital Discharge	YES	NO
Genital Itching	YES	NO
Musculoskeletal		
Joint Pain	YES	NO
Joint Stiffness	YES	NO
Muscle Pain	YES	NO
Muscle Stiffness	YES	NO
Neck Pain	YES	NO
Back Pain	YES	NO
Muscle Cramps	YES	NO
Muscle Twitching	YES	NO
Endo/Heme		
Easy Bruising	YES	NO

Easy Bleeding	YES	NO
Easily Over Heated	YES	NO
Cold Intolerant	YES	NO
Low Libido	YES	NO
Erectile Dysfunction	YES	NO
Breast Abnormality	YES	NO
Irregular Periods	YES	NO
Heavy Periods	YES	NO
PMS Symptoms	YES	NO
Frequent Thirst	YES	NO
Sweating	YES	NO
Hot Flashes	YES	NO
Hair Loss	YES	NO
Allergy/Immune		
Food Allergies	YES	NO
Environmental Allergies	YES	NO
Frequent Infections	YES	NO
Neurologic		
Headache	YES	NO
Dizziness	YES	NO
Numbness/Tingling	YES	NO
Fainting	YES	NO
Tremor	YES	NO
Memory Loss	YES	NO
Vertigo (Spinning/movements sensation)	YES	NO
Difficulty with Balance	YES	NO
Psychiatric		
Anxiety	YES	NO
Depression	YES	NO
Hallucination	YES	NO

Full Name: ____ Email Address: ______________________________________

Whom may we thank for referring you? ____

Can your acupuncturist contact you periodically by email? □ Yes □ No

What is the reason for today's visit? (List up to three conditions) Numeric Rating (1 less severe, 10 more severe)

1.	1	2	3	4	5	6	7	8	9	10
2.	1	2	3	4	5	6	7	8	9	10
3.	1	2	3	4	5	6	7	8	9	10

How long have you had these conditions? ____________________________________ Have you had these before? □ Yes □ No

If yes, when? ______________________________ How long previously? ____

Is this condition due to: □ Auto Accident □ Injury/Trauma □ Work-related □ Date of Onset: _________________________

Have you sought other treatment or consulted another medical professional for this condition? □ Yes □ No

If yes, what treatments and when? ____

Were these treatments helpful? □ Yes □ No Explain: ____

What are your strengths in terms of current health and wellness? ____

Short term health goals (1-4 weeks): ____

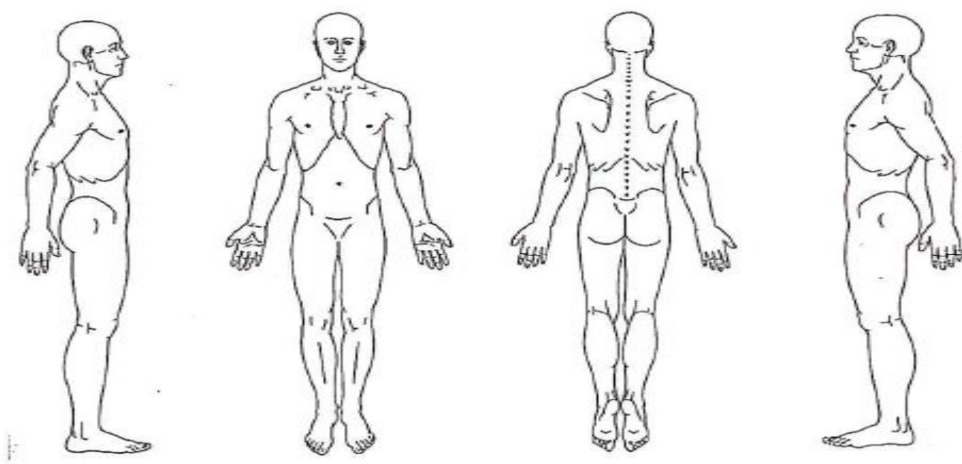
Long term health goals (1-12 months): ____

Pain

Are you currently experiencing acute or chronic pain? □ Yes □ No Describe: ____

What seems to be the initial cause: ____

What makes it worse? ______________________________ What makes it better? ____________________________________



Please shade in your pain pattern above using this table:

Ache	Numbness	Pins & needles	Burning	Stabbing
^^^^^	•••••••	00000000	XXXXX	/////////

ALL PATIENTS: Please circle YES or NO:

☐ Taking a blood thinner (Coumadin/Warfarin/Plavix/other) YES NO
☐ Have a Pacemaker YES NO
☐ Taking Lithium YES NO

Have you received acupuncture before? ☐ Yes ☐ No If so, where/when? ______________________________
Are there any issues of emotional/physical/sexual trauma or abuse you would like to discuss? ☐ Yes ☐ No
Are there any other issues or concerns not addressed that you would like to discuss? ☐ Yes ☐ No Explain: ____________________

WOMEN: **Only complete if the reason for your visit is related to fertility support or women's health.**

Age at first menstrual period: __________ Age at menopause: ___________ Number of days between periods: __________

Number of days of flow: ________ Color of flow: ________ Clots? ☐ Yes ☐ No Color: __________

Number of pads/tampons you use per day: Day 1 ____ Day 2 ____ Day 3 ____ Day 4 ____ Day 5 ____ Day 6+ ____

Have you been diagnosed with: ☐ Cysts ☐ Fibrocystic breasts ☐ Fibroids ☐ Endometriosis ☐ PCOS

Please check box next to all that apply and circle as follows: Before "B", During "D", or After "A" menses.

PAIN: ☐ Aching	B D A	☐ Burning	B D A	☐ Cramping	B D A
☐ Dull	B D A	☐ Sharp	B D A	☐ Stabbing	B D A
☐ Intermittent	B D A	☐ Constant	B D A	☐ "Bearing Down"	B D A
☐ Vaginal dryness	B D A	☐ Discharge___/Color________		☐ Odor_________	B D A
☐ Constipation	B D A	☐ Diarrhea	B D A	☐ Headache	B D A
☐ Swollen breasts	B D A	☐ Bloating	B D A	☐ Nausea	B D A
☐ Night sweats	B D A	☐ Insomnia	B D A	☐ Hot Flashes	B D A
☐ Mood swings	B D A	☐ Low appetite	B D A	☐ Big appetite	B D A
☐ Increased libido	B D A	☐ Low libido	B D A	☐ Cravings	B D A

Pregnancy History: Are you pregnant? ☐ Yes ☐ No Due Date? _____________ # of Pregnancies __________
# of Live births ____________ # of Abortions __________ # of Miscarriages __________
Are you currently trying to get pregnant? ☐ Yes ☐ No How long have you been trying to conceive? ____________________
If you have been trying to conceive, have you had medical testing for this issue? ☐ Yes ☐ No
Has your partner or spouse had medical testing for this issue? ☐ Yes ☐ No
If yes, what were the results? ____
Date/results of most recent (if applicable):
Gyn exam: ____________ PAP smear: _______________ Bone density scan: ______________ Mammogram: _____________

MEN: **Only complete if the reason for your visit is related to men's health.**

Date of most recent prostate check-up: _______________________ PSA results: ______________________________
Please check the box next to all that apply:

☐ Back Pain	☐ Testicular pain	☐ Groin pain	☐ BPH/prostate	☐ Rectal dysfunction
☐ Dribbling	☐ Incontinence	☐ Delayed stream	☐ Retention of urine	☐ Decreased force of stream
☐ Impotence	☐ Decreased libido	☐ Increased libido	☐ Premature ejaculation	☐ Weak erections (ED)

Are you and your spouse/partner currently trying to get pregnant? ☐ Yes ☐ No
If you have been unable to conceive, have you had medical testing for this issue? ☐ Yes ☐ No
If yes, what were the results? ____