YIN YANG ACUPUNCTURE CHANNEL, PLLC
Lisa Orlando, Lic. Ac.; Diplomate of Acupuncture (NCCAOM)
335 W 85th St, #3A, New York, NY
(917) 783-8998 | YinYangChannel085@gmail.com

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Today's date:_____

Patient Name: _____

*Address:_____

_____

*if you have insurance, please give the address your provider has

Birthdate:_____ Age:_____ Sex:_____ Height:_____ Weight:_____

**Signature:_____

**Your signature above is required in the event your insurance provider requests this document

Best contact phone number:_____

Email:_____

Best way to confirm appointments?:_____

Insurance Provider:_____

Insurance Phone Number:_____

Member ID:_____

Primary Care Physician:_____

Primary Care Physician Phone Number:_____

YIN YANG CHANNEL

Emergency Contact Person:_____ Relationship: _____

Emergency Contact Person contact info: _____

Occupation:_____

Interests:_____

Have you received acupuncture/cupping before? Yes: _____ No:_____

If yes, what for?: _____

_____

Primary reason for acupuncture/cupping visit?_____

_____

_____

When did this condition begin?_____

List all previous treatments for this condition (including medications):_____

_____

_____

List any other medications you are taking currently: _____

_____

_____

Past Medical History (major conditions, date of onset/duration/treatment):_____

_____

_____

Family History (any major medical conditions): _____

_____

_____

How many children did your birth mother have?: _____

And what is your birth order (1st, 2nd, etc.):_____

How do you feel about acu needles?: Like them _____ Don't like them_____ Not sure _____

Are you interested in being treated with other Chinese Medical modalities like medical massage, essential oils, gua sha?: Yes_____ No _____

I often use a diffuser with essential oils: Yes_____ No _____

Do you have any scent allergies?:_____

DIET AND LIFESTYLE:

Food allergies:_____

Dietary restrictions:_____

Cravings: _____

Herbs/Supplements:_____

Frequency of: Alcohol?_____ Coffee?_____ Tea?_____

Smoking of any kind?: Yes_____ No_____

How many 8 oz. cups of water do you drink a day?_____

Exercise (type and frequency)_____

_____

A typical day's diet: _____

_____

_____

_____

YIN YANG CHANNEL

GENERAL SYMPTOMS (CURRENT): Please mark with an "X" only if it applies to you

- poor / increased appetite?:_____
- weight loss/gain?:_____
- fatigue?:_____
- irritable?:_____
- depressed?:_____
- anxious?_____
- prefer hot/cold drinks?:_____
- sweat easily/rarely?:_____
- night sweating?:_____
- fever / chills?:_____
    - do they come on at a particular time of day or night?_____
    - Temperature?: _____
- cold hands/feet?:_____
- poor circulation?:_____
- numbness & tingling in hands/feet?:_____
- muscle cramps/weakness?:_____
- bruise easily/bleed?:_____
- dry skin?:_____
- itchy skin?:_____
- rashes/eczema/psoriasis/acne?:_____
  _____
- headache/migraine?:_____
- dizziness/vertigo?:_____
- blurred vision?:_____
- eye pain/tearing/red/itchy?:_____
- TMJ/facial pain?:_____
- sinus disorder/pain/pressure?:_____
- runny nose (acute or chronic)?:_____
- swollen glands?:_____
- sore throat?:_____
- difficulty swallowing?:_____
- decreased hearing?:_____
- neck/shoulder pain?:_____
- upper back pain?:_____
- lower back pain?:_____
- ringing in ears?:_____
    - high/low pitch?:_____
- gum/teeth problems?:_____
- hair loss?:_____
- shortness of breath?:_____
- loss of sense of smell?:_____
    - how long?:_____
- flu-like muscle/body aches?:_____
- brain fog?:_____
- chest tightness?:_____
- asthma/wheezing?:_____
- coughing?_____dry?:____
  hacking?:____ copious?:____
  sticky?:_____ bloody?:_____ color of phlegm?:_____
- palpitations?:_____
- irregular heartbeat?:_____
- low blood pressure?:_____
- indigestion?:_____
- gas/flatulence?:_____
- bloating?:_____
- belching/burping?:_____
- acid regurgitation?:_____
- nausea/vomiting?:_____
- foul breath?:_____
- diarrhea?:_____ loose stools?:_____
  constipation?:_____
- blood/mucous in stools?:_____
- intestinal cramping?:_____
- hemorrhoids?:_____
- urination
  frequent?:_____ urgent?:_____
  bloody?:_____ painful?:_____
  burning?:_____ cloudy?:_____
  incontinent?:_____
  night-time?:_____
- history of urinary tract infection (UTI)?:___
  _____
- the color of morning urine?
  pale yellow:____ color of apple juice:_____
  darker than apple juice:____

Is there anything else you'd like me to know to help me better treat you?:_____

_____

_____

_____

PLEASE DO NOT LEAVE BLANK:

difficulty falling asleep?:_____

do you awaken during night?:_____

what is your usual bedtime?:_____ time you usually rise in the AM?:_____

FOR WOMEN ONLY - GYN:

age and onset of menses?:_____ length of cycle?:_____

regular/irregular?:_____ duration of flow?:_____

color of flow?:_____ clots?:_____

menstrual pain? cramping? bloating?:_____ location?: _____

breast distention? tenderness?:_____

mood changes?:_____

headache?:_____

low back pain?:_____

radiating pain?: _____ location?: _____

date of last period?:_____ method of contraception:_____

vaginal discharge?:_____ color?:_____ duration?:_____

history of fibroids/ovarian cysts?:_____

history of urinary tract infections connected to cycle?:_____

date of last Pap smear?:_____ # of miscarriages?:_____

Are you currently pregnant?:_____ # of children?:_____

age of menopause?:_____