Yuri Belopolsky, M.Ac.
Family Acupuncture and Holistic Medicine
30 ½ George Street
Kittery, ME 03904
207-240-4100

Today's Date: _____

We would like to get to know you! Please fill out this questionnaire in as much detail as possible. Please do not write in the areas for office notes. Thank you!

Name:		Home Phone:	
Street Address:		Cell Phone:	
City, State and Zip Code:		Work Phone:	

Primary Care Provider (PCP):		PCP Phone:	
Emergency Contact:		Emergency Contact Phone:	
Insurance Carrier:		ID Number:	
		Group Number:	
Employer:			

Date of Birth:		Marital Status:	
Height:		Weight:	
Age of your mother when you were born:			
Age of your father when you were born:			

Who referred you to Family Acupuncture and Holistic Medicine?	

Have you been treated by acupuncture or Oriental Medicine before?	
If you have, when were you treated and who treated you?	

Why are you seeking treatment?	

When did this condition begin? (Please provide as much detail as possible)	

How does this condition interfere with your daily activities (work, sleep, exercise, sex etc.)?

What diagnosis or diagnoses have you been given for this condition or problem?

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What types of treatments have you tried? How were the treatments beneficial or problematic?

Office Notes: Chief Complaint and Associated Symptoms

Office Notes – Other Complaints:

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Medical History – Please ✓ if applicable and indicate date/age that this condition was noticed.

☐ Cancer	☐ Hepatitis	☐ High Blood Pressure
☐ Diabetes	☐ Seizures	☐ Rheumatic Fever
☐ Heart Disease	☐ Venereal Disease	☐ Thyroid Disease
☐ Other (please specify):		

☐ Scarlet Fever	☐ Mumps	☐ Chicken Pox
☐ Other (please specify):		

Have you had any surgeries? Please specify nature and date of surgery:

Have you experienced any significant trauma (auto accidents, falls etc.)? Please specify nature and date of trauma.

Office Notes – hospitalizations, surgeries and injuries:

Please list any allergies that you have (drugs, chemicals, foods, seasonal):

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Please specify the medical conditions that your parents have had prior to your birth:	
Lung conditions:	
Kidney conditions:	
Liver/Gall bladder conditions:	
Heart conditions:	
Gastrointestinal conditions:	
Other:	

Please list **all** medications, supplements and herbs have you taken within the past two months. Please specify the dosage and frequency.

Medication	Dosage	Frequency

Office Notes – chills, fever, sweating:

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Please describe your typical daily diet:

Morning	Afternoon	Evening

Do you have any peculiar tastes or smells? Please specify.

Please specify how much of each beverage you drink per day.					
Water		Tea		Soda	
Coffee		Milk		Other (please specify):	

Do you smoke? If yes, how much?	

How many alcoholic beverages do you drink per week?	

Please describe any use of drugs for non-medicinal purposes.

Office Notes – thirst:

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Please ✓ each symptom that you have experienced in the past three months:

General symptoms					
☐	Poor sleep	☐	Change in appetite	☐	Fevers
☐	Night sweats	☐	Cravings	☐	Sweat easily
☐	Bleed or bruise easily	☐	Strong thirst (hot and cold drinks)	☐	Weight gain
☐	Sudden energy drop*	☐	Fatigue	☐	Weight loss
	*(specify time of day)			☐	Chills

Hair and Skin					
☐	Rashes	☐	Ulcerations	☐	Hives
☐	Itching	☐	Eczema	☐	Acne
☐	Dandruff	☐	Loss of hair	☐	Recent moles
☐	Changes in hair or skin texture (please specify):				
☐	Other hair or skin problems (please specify):				

Office Notes – skin:

Please ✓each symptom that you have experienced in the past three months.

Eyes					
☐	Poor vision	☐	Wear Glasses or Contacts	☐	Eye Pain
☐	Night Blindness	☐	Blurry Vision	☐	Eye Strain
☐	Color Blindness	☐	Spots in Front of Eyes	☐	Cataracts

Please ✓each symptom that you have experienced in the past three months.

Ears					
☐	Poor hearing	☐	Ringing in Ears	☐	Earaches

Nose and Throat					
☐	Recurrent Sore Throat	☐	Sores on Lips or Tongue	☐	Nose Bleeds
☐	Swallowing problems	☐	Sinus Problems	☐	Facial Pain

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Head		
☐ Vertigo	☐ Grinding Teeth	☐ Migraines
☐ Dizziness	☐ Teeth Problems	☐ Concussions
☐ Jaw Clicks	☐ Headaches*	
*Please specify where and when:		
☐ Other head or neck problems (please specify):		

Office Notes - Face, Ear, Nose and Throat:
Office Notes - Head:

Please ✓each symptom that you have experienced in the past three months.

Neuropsychological		
☐ Seizures	☐ Lack of Coordination	☐ Loss of Balance
☐ Areas of Numbness	☐ Tremors	☐ Poor Memory

Cardiovascular		
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Chest Pain
☐ Irregular Heartbeat	☐ Swelling of Hands	☐ Fainting
☐ Cold Hands and Feet	☐ Difficulty in Breathing	☐ Swelling
☐ Other Heart or Blood Vessel Problem*	☐ Phlebitis	☐ Blood Clots
*Please specify:		

Respiratory		
☐ Cough	☐ Coughing Blood	☐ Asthma
☐ Bronchitis	☐ Pain with a deep breath	☐ Pneumonia
☐ Difficulty in Breathing – Lying Down	☐ Production of phlegm – What Color?	
☐ Other head or neck problems (please specify):		

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Office Notes – Lung, Heart and Chest:

Please ✓each symptom that you have experienced in the past three months.

Gastrointestinal					
☐	Nausea	☐	Indigestion	☐	Diarrhea
☐	Vomiting	☐	Constipation	☐	Gas
☐	Belching	☐	Blood in Stools	☐	Black Stool
☐	Bad Breath	☐	Rectal Pain	☐	Hemorrhage
☐	Poor Appetite	☐	Abdominal Pain or Cramps	☐	Chronic Laxative Use
☐	Other Stomach or Intestinal Problems (please specify):				

Office Notes – Digestion:

Please ✓each symptom that you have experienced in the past three months.

Urinary-Genital					
☐	Pain upon urination	☐	Urgency to Urinate	☐	Decrease in Urine Flow
☐	Blood in Urine	☐	Unable to hold urine	☐	Impotence
☐	Kidney Stone	☐	Sores on Genitalia		
	Color of Your Urine:		How often do you wake at night to urinate?		
☐	Other Genital or Urinary System Problems (please specify):				

Office Notes – Bowel Movement and Urination:

Please ✓each symptom that you have experienced in the past three months.

Musculoskeletal					
☐	Neck Pain	☐	Muscle Pain	☐	Knee Pain
☐	Upper Back Pain	☐	Middle Back Pain	☐	Lower Back Pain
☐	Muscle Weakness	☐	Foot/Ankle Pain	☐	Shoulder Pain
☐	Hip Pain	☐	Hand/Wrist Pain		
☐	Other Joint or Bone Problems (please specify):				

Office Notes – Musculoskeletal:

Female Patients: Please ✓each symptom that you have experienced in the past three months.

Reproductive and Gynecologic					
☐	Unusual Periods (heavy, light etc.)	☐	Vaginal Discharge	☐	Irregular Periods
☐	Spotting Between Periods	☐	Breast lumps	☐	Menstrual Pain
☐	Menstrual Clots – Small - Large	Large			

Number of pregnancies:	
Number of live births:	
Number of premature births:	
Number of miscarriages:	
Number of abortions:	
Date of your last period:	
Number of days between periods:	

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Number of days that your period lasts:	
Changes in body /psyche prior to your period:	

Do you practice birth control? What type do you use and for how long?

Is there any chance that you are currently pregnant?	

Office Notes – Ob.-Gyn.:
Office Notes – Energy:
Office Notes – Sleep:
Office Notes – Likes and Dislikes:

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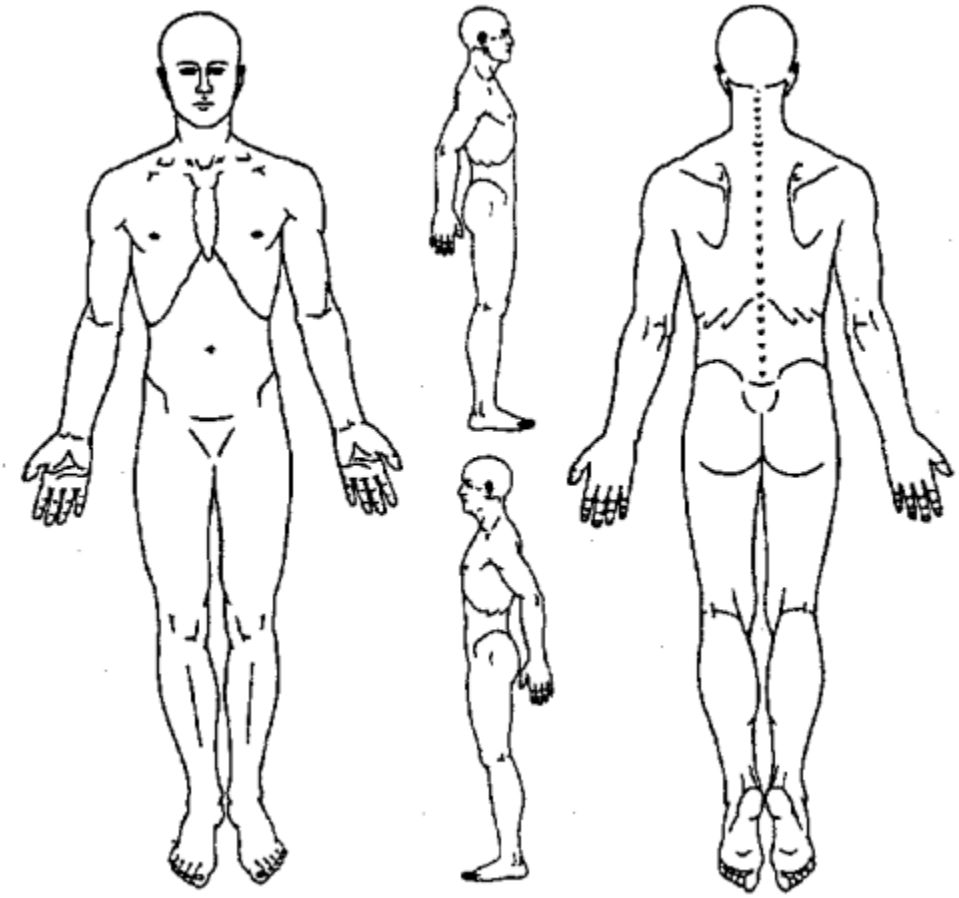
Office Notes – Self-Description:

Please indicate any painful or distressed areas:

Click to Draw



Mental/Emotional:

Please mark on the scale where you feel you are emotionally and mentally.

	1 – Mild	2	3	4	5- Strong
Joy					
Sadness					
Fear					
Anger					
Anxiety					
Overthinking					

How are you currently feeling?	

Is there anything else you would like us to know?	

Submit

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