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A warm welcome to you! In preparation for your first acupuncture appointment with Kristin Field, Dr. of Oriental Medicine and Holistic Healer, please be aware of the following:

After filling out the attached "Health History", please bring it with you at the time of your treatment.

Please bring with you any medications that you have taken, *even if you are not taking them currently*. Put them in a bag or box and *bring the actual substances with you*. Likewise, bring any vitamins, minerals, herbs, and food supplements, as well as any substances to which you are allergic. Dress in loose, comfortable clothing. Please do not wear a one-piece garment such as a jumper or dress which prohibits easy access to your abdomen and back.

An initial treatment for an adult will last approximately 2 hours; and 1 hour for a child. The treatment is generally a deep and profound experience. Clients have used the following words at the conclusion of the treatment to describe their feelings: "expansive", "light", "spacey", "sleepy", "relaxed", etc. It is thus advised that you not schedule any appointments following your treatment.

Before and after your treatment, it is best to avoid eating a big meal. Following your treatment, I recommend that you be gentle with yourself. Get plenty of sleep; drink lots of water; avoid drinking alcohol; avoid engaging with situations that cause you stress. Treat yourself to the kinds of things that are nurturing to you. Create the environment for yourself in which you can most benefit from this experience.

An initial appointment is $425 for an adult (18 years and older); $250 for a child (17 years and younger). Follow up appointments are $175 for an adult; $175 for a child. Payment by check, Visa, Mastercard or cash is due at the time of service. If you cannot make this appointment, please give me at least 24 hours notice, otherwise I will charge the full amount as I cannot fill the spot without sufficient notice.

Please refrain from smoking prior to your appointments.

You are welcome to call with any questions. Take good care!

Warmly, Dr. Kristin Field

Updated 4/2024

Health History Questionnaire for Patients

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

Name:

Street: City State Zip

Age: Height: Weight:

Home Phone: Work Phone:

Date/Place of Birth: Social Security Number:

Occupation: Marital Status:

In Emergency Notify:

Referred by:

Family Physician:

Insurance Carrier: Policy Number:

Have you tried acupuncture or Chinese herbal medicine before?

Main problem(s) you would like to address

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

Past medical history (please include dates)

☐Allergies:
☐Cancer
☐Diabetes
☐Hepatitis
☐High blood pressure
☐Heart disease
☐Seizures
☐Rheumatic fever
☐Surgeries
☐Venereal disease
☐Thyroid disease
☐Birth trauma (prolonged labor, forceps delivery, etc)
☐Other significant illness (describe)
☐Accidents or significant trauma (describe)

Other relevant medical history

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

Any other problems with stomach or intestines

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate? If so, how often?

Any particular color to your urine?

Any other genital or urinary problems

REPRODUCTIVE AND GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

Age at first menses Age at menopause Number of pregnancies

Time between cycles Duration of bleeding First day of last menses

Do you practice birth control? If so, what type? For how long?

Any other gynecologic problems

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pains
- ☐ Hip pain

Any other joint or bone problems

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems

COMMENTS

Please list any other problems you would like to discuss:

PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day?)
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin problems

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? when?)
- ☐ Jaw clicks

Any other head or neck problems

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Family Medical History

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Other

Occupation

Occupational stress factors (physical, psychological, chemical):

Lifestyle

Do you follow a regular exercise program? If so, please describe:

Please describe your average daily diet:

Please check any of the following habits that apply. How much and how often do you use them?

☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.):

Please describe any use of drugs for non-medical purposes:

Please mark painful or distressed areas on the charts below

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
≈	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
–	colder
+	hotter
Physical	
Ø	sores
*	rashes
« »	spasms