Jade Mountain Health
Andrew C. Maloney, L. Ac.
745 Poplar Avenue
Boulder, CO 80304
303.859.3125
www.jademtnhealth.com

HEALTH HISTORY QUESTIONNAIRE

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

Today's Date: _____

Name: _____ **Email:** _____

Address: _____ **City:** _____ **Zip:** _____

Home: (_____) _____ **Work:** (_____) _____ **ext.** _____ **Cell/other:** (_____) _____

Age: _____ **Date of Birth:** _____ **Place of Birth:** _____ **Marital Status:** _____

Family Physician: _____

Emergency Contact: _____

Referred by: _____

Have you been treated with acupuncture or Oriental medicine before? ◯ Yes ◯ No

Main problem(s) you would like us to help you with: _____
_____

When did this condition begin? (Be as specific as possible.) _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____
_____

Have you been given a diagnosis for this problem? If so, what? _____

What kind of treatment have you tried, and with what result? _____
_____
_____

Your significant illnesses (please indicate dates in space provided, if possible):

- ☐ Cancer (_____)
- ☐ Diabetes (_____)
- ☐ Hepatitis (_____)
- ☐ Heart disease (_____)
- ☐ Seizures (_____)
- ☐ High blood pressure (_____)
- ☐ Venereal disease (_____)
- ☐ Other (please describe): _____

Surgical procedures: _____

_____

_____

Significant traumas (auto accident, fall, etc.): _____

_____

_____

Unusual conditions present during your birth (prolonged labor, forceps delivery, etc.): _____

_____

Allergies (drugs, chemicals, foods, etc.): _____

_____

Has anyone in your family suffered from:

- ☐ Diabetes
- ☐ Cancer
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Seizures
- ☐ Asthma
- ☐ Allergies
- ☐ Other (please describe): _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

Occupation: _____

Occupational stress (physical, psychological, chemical, etc.): _____

Do you have a regular exercise program? ◯ Yes ◯ No Please describe: _____

_____

Have you been on a restricted diet? ◯ Yes ◯ No Please describe: _____

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Other: _____

Do you smoke? ◯ Yes ◯ No If so, how often and how much? _____

How many caffeinated beverages do you drink per day or week? _____

Please check if, *in the last three months*, you have experienced the following:

GENERAL

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop (During what time of day?_____)
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Weight loss
- ☐ Strong thirst (cold or hot drinks)
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain

SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair/skin texture
- ☐ Other (please describe): _____
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Glasses/contact lenses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problem
- ☐ Grinding teeth
- ☐ Teeth problem
- ☐ Headaches (What part of the head, and when?) _____
- ☐ Other (please describe): _____
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Other (please describe): _____
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Other (please describe): _____
- ☐ Coughing up blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breathing

GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Other (please describe): _____
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Chronic laxative use
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids

GENITO-URINARY

- ☐ Painful urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Other (please describe): _____
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals

Do you wake up at night to urinate? ◯ Yes ◯ No How often? _____
Any particular color to your urine? ◯ Yes ◯ No Please describe: _____

GYNECOLOGY AND PREGNANCY

- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Unusual character of period (heavy or light)
- ☐ Other (please describe): _____
- ☐ Painful periods
- ☐ Vaginal sores
- ☐ Change in body/emotions prior to period
- ☐ Clots
- ☐ Breast lumps

First date of last menstrual period: _____ **Duration:** _____
Number of days between menstrual periods: _____ **Date of most recent Pap:** _____

Number of pregnancies: _____ **Number of births:** _____ **Number of premature births:** _____
Number of miscarriages: _____ **Number of abortions:** _____

Do you practice birth control? ◯ Yes ◯ No
What method, and for how long? _____

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Other (please describe): _____
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Hip pain

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Other (please describe): _____
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety

Have you been treated for emotional problem? ◯ Yes ◯ No

Have you ever considered or attempted suicide? ◯ Yes ◯ No

COMMENTS

Please describe any other problems you would like to discuss: _____
_____
_____

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DISCLOSURE STATEMENT

Welcome to Jade Mountain Health. Please read and sign this disclosure. If you have any questions, please feel free to ask for clarification before you sign it.

Initial Consultation: $175

Acupuncture Treatment: $115 **Herbal Consultation: $95** **Cupping Therapy: $85**

Herbs and poultices: Prices Vary

Andrew C. Maloney received a four-year M.S. in Oriental Medicine from the Southwest Acupuncture College, Boulder Campus. He is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) and is a licensed acupuncturist (Lic. # ACU925) in the State of Colorado; he has never had a license, certificate, or registration suspended or revoked.

Mr. Maloney is trained and experienced in the recommendation and application of adjunctive therapies such as gua sha, cupping, moxibustion, tui na, and the use of herbal poultices. He is also a trained Chinese herbalist with experience both in the U.S. and abroad. All of these adjunctive therapies fall under the definition of traditional oriental medicine. He worked and studied acupuncture in Taiwan for five years (1994-1999); in the last year before returning to the U.S., he apprenticed under Dr. Yo Mao Ling in Luo Dong, Taiwan.

This disclosure statement complies with the State of Colorado, Department of Regulatory Agencies; and C.R.S. §§ 12-29.5-101, *et seq*. This clinic strictly adheres to all rules and regulations set forth by the Department of Health, including sanitation of the office and Clean Needle Technique procedures for the sterilization, a practice in which Mr. Maloney is certified.

You are entitled to receive information about methods of therapy, the technique used, and the duration of therapy (if known). You may seek a second opinion from another health care professional or terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the Department of Regulatory Agencies, 1560 Broadway #1550, Denver, CO 80202 (303.894.7758). Any services offered by Mr. Maloney are not intended to substitute for those offered by a licensed medical doctor when needed. Referrals are made for further treatment when appropriate.

I have read the above statements and I understand it to my satisfaction. I certify that I have had the opportunity to have any and all questions answered about this information and I freely seek the services offered. I also understand that payment is expected at the time of service.

_____ _____

Signature Date

_____

Print Name