Blair Sylvan Grey, Doctor of Oriental Medicine
5 Element Acupuncture and Holistic Consultations
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Contact Information

Your contact information is confidential and will not be shared.

First Name ________________________ Last Name ________________________

Marital Status ________________________ Date of Birth ________________________

Contact Phone ________________________ Email ________________________

Street Address ____

City ________________________ State __________ Zip code ______________

Emergency Contact ____
(Name) (Relationship) (Phone)

Primary Care Physician ____
(Name) (Phone)

Do you have allergies or issues with dogs? I have a dog that sometimes comes with me; is that ok?

____

Who may I thank for referring you? ________________________________

Health Questionnaire

Main Health Concern

____

____

____

____

____

____

How does this problem affect your daily activities?

When did you first notice symptoms?

If you have been diagnosed, what is the diagnosis?

Anything else you'd like to discuss or have concerns about?

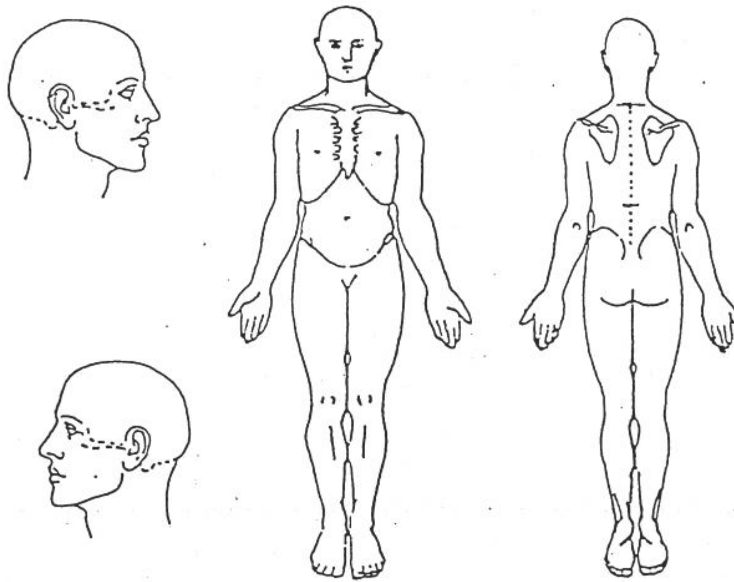
Hospitalizations/Surgeries/Accidents:

Allergies:

Family Health History

Family Member	Important Diseases/Illnesses	Age	Deceased Y/N

Please mark painful or distressed areas on the charts below. *If you're filling out this form in PDF and emailing it, we can mark the chart during our first session.*



Symbol	Reaction
Pain	
X XX XXX	little moderate strong
Swelling	
^ ^^ ^^^	slight moderate severe
Pulsing	
O OO OOO	slight moderate strong
Weakness/Temperature	
~ +	weak hot
Skin Problems	
*	skin issue

Lifestyle

Exercise *(check the most applicable)*

- ☐ Sedentary (No Exercise)
- ☐ Mild Exercise (i.e. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (workout/recreate, less than 4x/week for 30 minutes)
- ☐ Regular vigorous exercise (i.e., workout or recreate 4x/week for 30 minutes)

Diet

Are you dieting? Yes No

If yes, are you on a physician prescribed medical diet? Yes No

Number of meals you eat in an average day? ____

Describe your daily diet: ____

____

____

____

Caffeine: Number of cups/cans per day: Coffee__________ Tea__________ Cola__________

Tobacco: Packs of cigarettes/day____ Type__________ # of Years_____ Pipe _____Chew_______

Do you drink alcohol? If yes, how many drinks per week? ______________________________

Do you use recreational drugs? If yes, type:_______________________________________

Medications, Herbs and Supplements

Please list any drugs, herbs and supplements you currently take.

____

____

____

____

____

Mental Health

Is stress a major problem for you?	___Yes	___No
Do you feel depressed?	___Yes	___No
Do you panic when stressed?	___Yes	___No
Do you have problems with eating or your appetite?	___Yes	___No
Do you cry frequently?	___Yes	___No
Have you ever attempted suicide?	___Yes	___No
Have you ever thought seriously about hurting yourself?	___Yes	___No
Do you have trouble sleeping?	___Yes	___No
Have you ever been to a counselor?	___Yes	___No

What are you passionate about? ____

____

What are your Super Powers? If none currently, what would you like them to be? __________

____

Do you have a daily practice, stress relief activity or "reset" that assists you? What is it? _______

____

____

If you would like to share anything else, please email me what you would like to me to know.

Personal History

(Check all that apply)

General	__Poor Appetite	__Weight Gain	__Night Sweats
	__Insomnia	__Weight loss	__Fever
	__Disturbed Sleep	__Sweating easily	__Chills
	__Localized Weakness	__Bleeding/bruising	__Sudden energy drops
	__Cravings	__Tremors	__Poor Balance
	__Strong Thirst		
Skin and Hair	__Rashes	__Eczema	__Recent moles
	__Ulcerations	__Pimples	__Change in hair texture
	__Hives	__Dandruff	__Hair loss
	__Itching		
Head, Eyes, Ears	__Color Blindness	__Recurrent sore throats	
Nose, Throat	__Concussions	__Cataracts	__Nose bleeds
	__Migraines	__Blurry Vision	__Grinding Teeth
	__Glasses	__Earaches	__Sores on lips/tongue
	__Spots in front of eyes	__Ringing in ears	__Facial pain
	__Eye pain	__Poor hearing	__Gum/teeth problems
	__Poor vision	__Eye strain	__Headaches
	__Night blindness	__Sinus problems	__Jaw clicks
	__Photophobia	__TMJ	
Cardiovascular	__Dizziness	__High blood pressure	__Swelling of feet
	__Low blood pressure	__Fainting	__Blood clots
	__Chest pain	__Cold hands or feet	__Difficulty breathing
	__Irregular heartbeat	__Swelling of hands	__Phlebitis
	__Tightening in chest	__Palpitations	__Stroke
Respiratory	__Cough	__Bronchitis	__Frequent colds or flu

Respiratory ***continued***	__Asthma	__Shortness of breath	__Excessive phlegm
Gastrointestinal	__Nausea	__Belching	__Rectal pain
	__Vomiting	__Black stools	__Hemorrhoids
	__Diarrhea	__Blood in stools	__Abdominal pain/cramps
	__Constipation	__Indigestion	__Chronic laxative use
	__Gas/bloating	__Bad breath	__Crohn's
	__Parasites	__Diverticulitis	__Colitis
Genitourinary	__Pain in urination	__Incontinence	__Sores on genitals
	__Low to no sex drive	__Decrease in flow	__Impotence/frigidity
	__Blood in urine		
Musculoskeletal	__Neck pain	__Back pain	__Hand/wrist pain
	__Muscle pain	__Muscle weakness	__Shoulder pain
	__Knee pain	__Foot/ankle pains	__Hip pain
	__Sciatica	__Tendonitis	__Arthritis
	__Migraines	__Varicose Veins	
Neuropsychological	__Seizures	__Poor memory	__Anxiety
	__Frequent mood swings	__Depression	__Bad temper
	__Loss of balance	__Concussion	
Other Illness	__HIV positive	__Rheumatic fever	__Eating disorder
	__AIDS	__Hypoglycemia	__Jaundice
	__Epstein-Barr	__Diabetes	__Hepatitis
	__Mononucleosis	__Underweight	__Overweight

Women Only

Age at onset of menstruation: ______________ Date of last menstruation: ___________________________

Period occurs every ____ days.

Check all that apply:

Do you have:

- ☐ Heavy periods
- ☐ Irregularity
- ☐ Spotting
- ☐ Pain
- ☐ Discharge

Number of pregnancies ____

Number of live births ____

Are you:

- ☐ Pregnant
- ☐ Breastfeeding?

Have you had:

- ☐ D&C
- ☐ Hysterectomy
- ☐ Cesarean

In the last year, have you had a:

- ☐ urinary tract infection
- ☐ bladder infection
- ☐ kidney infection

At night, do you have:

- ☐ Hot flashes
- ☐ Sweating

At or around the time of your period, do you have:

- ☐ Pain
- ☐ Bloating
- ☐ Irritability
- ☐ Other symptoms

Have you experienced any:

- ☐ Breast tenderness
- ☐ Lumps
- ☐ Nipple discharge

Men Only

(Check yes or no)

Do you usually get up to urinate during the night?	___Yes	___No
Do you feel burning discharge from penis?	___Yes	___No
Has the force of your urination decreased?	___Yes	___No
Have you had kidney, bladder, or prostate infections in the last 12 months?	___Yes	___No
Do you have any problems emptying your bladder completely?	___Yes	___No
Do you have any difficulty with erection or ejaculation?	___Yes	___No
Any testicle pain or swelling?	___Yes	___No